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UNIVERSITY OF ALBERTA

UNITING VOCATION AND AVOCATION:
BECOMING A MIDWIFE IN ALBERTA PRIOR TO REGULATION

by

ALICE JOHANNA OUWERKERK ©

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE MASTER OF NURSING

FACULTY OF NURSING

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Alice Ouwerkerk

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Date: 26 Jan 1995

But yield who will to their separation,
My object in living is to unite
My avocation and my vocation
As my two eyes are one in sight.
Only where love and need are one,
And the work is play for mortal stakes,
Is the deed ever really done
For Heaven and the future's sakes.

Robert Frost, Two Tramps in Mud Time
(lines 65-72)

THE UNIVERSITY OF ALBERTA
FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled UNITING VOCATION AND AVOCATION: BECOMING A MIDWIFE IN ALBERTA PRIOR TO REGULATION submitted by ALICE JOHANNA OUWERKERK in partial fulfillment of the requirements for the degree of MASTER OF NURSING.

Peggy Anne Field
Dr. P.A. Field (Supervisor)

Professor J. Relyea

Dr. H. Northcott

Date: 26 January 1995.

DEDICATION

This thesis is dedicated to my mother

JOHANNA VOOR DEN DAG OUWERKERK

who first told me about birth,
and to my daughters,

TAHIRIH NICOLE REMPEL
and
SHOLEH JASMIN GUINNEVERE GRACE OUWERKERK-REMPEL

who reminded me that it was so.

Abstract

The researcher studied the process of becoming a midwife in Alberta from 1980 to 1993, prior to it's designation as a regulated profession. A grounded theory methodology was used, in a combined retrospective and concurrent time frame.

The data generated a common definition of "midwife" and a common theory of the process of becoming a midwife in Alberta. A preparatory period, encompassing the activities **discovering goodness of fit** and **conceptualizing midwifery** culminated, through a period of **loss of focus/refocusing**, in the decision **"I am going to become a midwife."** Active becoming took place in the intertwined activities **acquiring knowledge and skills for midwifery** and **evaluating and finding evidence of goodness of fit**. The convergence of the learner's personal evaluation of herself as sufficiently knowledgeable, and some external evaluator's designation as appropriately fit resulted in the exit from the process by way of the statement, **"I am a midwife."** The Basic Social Psychological Process **"Learning according to a relational ethic"** emerged gradually in the preparatory period, fully informed the active process and persisted in practice, as indicated by its consistency with the informants' definition of midwifery.

ACKNOWLEDGEMENTS

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To the women described in this study, the midwives who dared to follow their hearts, I extend my most sincere appreciation and respect. You are heroes and most worthy exemplars for those of us who follow behind you. Your work is truly done "for heaven and the future's sakes".

Many friends played a significant role in their provision of support and challenge in both my pursuit of midwifery and the completion of this thesis. They did this in many ways--emotionally, intellectually, and especially spiritually. Renie Zeitz has been one of my oldest and dearest friends. Her support, love and prayers during this time have been irreplaceable. Gerry Dobek has been unfailing in her friendship for many years, and though our phone bills have suffered, our spirits will always be nourished by each others' loving encouragement and understanding. Annita Damsma, my partner in this

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Finally, I acknowledge my profound gratitude and debt to God, whose loving care and bounty made this work possible and enriched my life beyond any expectations or deserving. As a Baha'i, I pray that this work be accepted in the spirit of worship it is offered. In the words of the immortal Baha'i heroine, Tahirih, "You can put me to death, but you cannot stop the emancipation of women". My life as well is dedicated to that noble cause.

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UNITING VOCATION AND AVOCATION: BECOMING A MIDWIFE IN ALBERTA PRIOR TO REGULATION

CHAPTER I - INTRODUCTION

In early Canadian society, as it was throughout history, women were attended by other women at the time they gave birth. Sometimes these attendants were relatives and neighbours, and at other times they were specialized helpers, called midwife ("with woman"), sage-femme ("wise woman") or various other names. Regardless of her status, the woman called to be present at the birth was almost always known to the birthing woman (Mason, 1987). This fact, together with the various characteristics of early pioneer communities, led to the development of what has been coined a "birthing culture" (Mason, 1987). With the growth of the medical profession from the mid nineteenth to early twentieth century, this birthing culture, centred around women, home, self-reliance and midwives, was eventually replaced by a birthing atmosphere characterized by hospitals, medical intervention, secrecy and fear (Barrington, 1985; Mason, 1987). By the mid twentieth century, midwifery and the woman-centred birthing culture were virtually unknown in Canada, other than in outpost centres.

With social changes and the resurgence of the women's movement in the 1960's and early 1970's, there emerged an interest in the reclamation of birth and the birthing culture. This consumer interest facilitated the emergence of professional caregivers who would support these families' desire to birth in their own unique fashion while providing skilled observation and advice. This movement started in British Columbia and eventually spread across Canada (Barrington, 1985; Association for Safe Alternatives in Childbirth, Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth & Childbirth Education of Central Alberta [ASAC, CAPSAC & CECA], 1990a, 1990b, 1990c; Mason, 1987).

In Alberta, this movement was initially supported by a minute number of physicians--including Dr. Ben Toane in Edmonton (ASAC et al, 1990b) and Dr. Una Underwood in Calgary (ASAC et al, 1990a). When the College of Physicians and Surgeons in the early 1980's ruled that its members would lose their licensure if they continued to attend home births, the nurses and midwives who had been working with these physicians assumed primary midwifery duties (ASAC et al, 1990a,b). This small group of independent midwives has offered midwifery services despite the absence of recognition and legislation in this province and in the face of legal (Burtch, 1987) and personal challenge (personal conversation, S. Pullin, 23 November 1992).

Concurrent with this historical process, and continuing at the present time, there has raged a debate regarding comparative birth outcomes. The medical profession has repeatedly claimed superior outcomes, in terms of morbidity and mortality, in medically supervised and/or hospital-based births. However, analysis by independent researchers indicates that the outcomes of midwife-attended and/or home-based birth is either equivalent or superior to medically supervised births (Barrington, 1985; Burtch, 1987; Ernst & Gordon, 1979; Hoff & Schneiderman, 1985; Mason, 1987; Scupholme, McLeod & Robertson, 1986, and others). It has been the medical profession's **claim** of superior outcomes and their social power which enabled them to nearly eliminate the "birthing culture" and midwifery profession (Barrington, 1985; Mason, 1987). It is noteworthy that those midwives who resisted the pressure to desist from practice did so not only at great cost to themselves, but with equivalent or superior outcomes.

Significance of the Study

Today, midwifery is emerging as a significant component of the health-care system throughout Canada. In Alberta, recent legislation entrenched midwifery as an independent health discipline (Government of

Alberta, 1992), thereby setting in motion the movement towards regulation and legitimation. Historically, this event marks a turning-point in the sphere of practice and influence of independent midwives. It seems self-evident that as the environment of practice changes, the characteristics of the midwives and of midwifery in this province will also change. Their remarkable persistence, notable outcomes, and the probable impending change of practice environment mandate a full description and definition of this group of midwives and their practice.

Statement of Research Purpose

A full study of this population would entail several projects and methodologies. In this project, the process by which a number of Alberta women **became** midwives was investigated. In other words, what was it that stimulated, facilitated and entrenched their self-definition as a practitioner of midwifery? The specific question which guided the research was:

What is the process through which a woman moves as she changes from regarding herself as "not a midwife" to "a midwife"?

CHAPTER II - LITERATURE REVIEW AND ANALYSIS

Introduction

An understanding of three broad topics was considered to be essential at the outset of this project: first, knowledge of the literature and research regarding midwives and midwifery; second, an understanding of the various connotations of the concept "becoming" and third, foundational familiarity with the literature and theory regarding socialization. To date, the literature regarding midwifery suggests that a distinct process of becoming a midwife does occur within the greater midwifery community. This process can be identified in terms of two different indicators. First, there are specific descriptors of the process. Second, there is reference to a common role and/or common attributes (attitudes, behaviours, skills) which intimate that midwifery is a defined group, and that therefore the individuals who make up that group undergo a distinct process of becoming. A representative, though not exhaustive, literature review clarified the significance of these indicators, and demonstrated the importance of the crucial inter-relationship between maternity health care, midwifery, and the special process of women becoming midwives.

Exploration into and analysis of the concept "becoming" was carried out. Such concept analysis enhances sensitivity to the various shades of meaning which may become evident in the process under exploration. The essential findings of this work will be reported here.

Last, an inquiry into sociological theory and literature pertinent to the nature of the process under exploration, particularly as informed by the distinct nature of this specific group, was carried out. As will become clear, it was deemed inappropriate to pursue previous work in professional socialization, both because of the absence of previous research on professional socialization in midwives, and because of the unique nature of the population being studied in the current project. Hence, a broad review of role attainment theory, in particular as put forward by the symbolic interactionist approach, will be presented.

Midwifery Literature Review

Literature describing the midwifery profession generally is scant, and that describing this population of Alberta midwives is virtually non-existent. An international definition of a midwife was drafted by the World Health Organization in 1972 (Sweet, 1988). While this definition outlined the expected standards for education and sphere of practice, it did not describe some of the "attitudes behind the delivery of care and the soft variables of human interaction" (Morten, Kohl, O'Mahoney & Pelosi, 1991; p.283) which tend to characterize a given profession, and which may be the signal attributes which direct practice and outcomes (Yalom, 1980, in Morton et al, 1991). It was these elements that were particularly pursued in the literature review, and from which the twin indicators were derived. The findings will be briefly reviewed and discussed insofar as they apply to the "becoming" process for midwives.

Historical Anecdotes

There are several historical anecdotes regarding midwives (Cox, 1973; Cust, 1990; Rowe, 1990; Smulders, 1990; Ulrich, 1990, and others). These stories consistently portray the midwife as a heroine of the community, possessing such qualities as bravery (she would overcome incredible odds to attend a woman at delivery), self-sacrifice (often she was paid very little or nothing at all), leadership (she would lend her efforts to matters of social reform), devotion (she would stay with the woman for long periods of time, and for as long as she was needed), and wisdom (she was called to attend the sick even when it was not a maternity case). Although it is possible that these **particular** women were the subjects of these accounts because of their exemplary practice, it is interesting to note that the only negative accounts that this author found were those related by medical practitioners, who often referred to midwives as "untrained, unkept, gin soaked harridans unfit for the work they were supposed to do, and a menace to the health of any woman whom they might attend." (William B. Hendry, M.D., Obstetrician, Chairman of the Maternal Mortality Committee of the Canadian Medical Association, 1931, in Mason, 1987, p.197). One derives the impression from these early accounts that there were common attributes among midwives, not the least of which was the strength and determination required to withstand the criticism and opposition of the medical community.

However, the process by which these women came to be so exceptional is rarely mentioned. Did the practice of midwifery attract exceptional women, did the practice somehow facilitate the development of exceptional qualities or does the nature of the birthing experience somehow promote the lionization of one's attendants? Mason (1987) suggested that the midwife's role was so embedded in the birthing culture that it could not be distinguished from "the life of the community, and was intimately a part of women's culture...Midwifery was thus rarely a trade or a profession in any sense that was parallel to the professional ambitions of doctors" (p.198). The fact that definitive conclusions cannot be drawn from the anecdotal referents to this historical group illustrates the importance of describing the population in this study, who will also shortly become historical fact. Indeed, it is expected that one consequence of this study will be the potential delineation of consistencies and variations over time in the process of becoming a midwife.

Descriptive Literature

In the current non-research literature written by midwifery practitioners, frequent references are made to the unique attributes of midwives, particularly sensitivity, humility, attentiveness, persistence, autonomy and an alternative vision. These qualities, which are considered to have a direct impact on practice, are sometimes related to education and learning. Armstrong and Feldman (1990), a midwife and a journalist, respectively, in a comparison of midwifery and medical textbooks, suggested that "...doctors aren't encouraged to be emotionally and psychologically sensitive during training. Midwives, by contrast, are required to do so. Ploddingly, painstakingly, the midwifery text teaches its students to listen" (p.152). Davis (1987), a practising midwife and author of a popular midwifery text, related attributes to practice, but not explicitly to education. She asserted that "the essence of midwifery is staying sensitively in the moment, or in other words, being humble and paying attention" (p.5). In contrast, the primary requirement for the individual practitioner was suggested to be persistence:

> ...she must face tremendous obstacles in establishing and maintaining a practice..This takes strong, independent character, willingness to go against society's mores. Herein lies the secret to the midwife's notoriety; she is a rebel, and a female one at that! (p.5)

Paralleling this notion of midwife as rebel, Flint (1986), a practising midwife and co-founder of the Association of Radical Midwives in the U.K., describes the midwife's reality as outsider in terms of a historical/mythological perspective:

> The patron saint of midwives probably gives us more insight into the personality of the midwife than anything else...a Roman pagan goddess, Juno Lucina, goddess of sensuality and sexuality. Here is the root of the mystery, the magic and sensitivity of the midwife, her history as the wise woman, the witch burned at the stake, the healer, the helper and comforter of laboring women. (p.14)

The common threads of a number of distinct attributes are evident in these accounts, as is the notion that these unique characteristics are pivotal to the midwife's practice and the outcomes of her practice. Once again, however, there is little description of how she came to possess these attributes: whether the profession attracted a specific type of woman, or whether these traits were learned in the process of becoming a midwife. Regardless, the midwife is repeatedly described in terms of strength, independence, and sensitivity, and these descriptions are consistently centred around her relationship with the birthing woman.

Similar themes can be identified in the writings of other professionals. Boyer (1990), president of the Carnegie Foundation for the Advancement of Teaching, asserts that "the celebration of self-reliance is, in my opinion, what midwifery, at its best, is all about....Throughout history, midwives have survived precisely because they've been boldly responsive to human need, willing to challenge ossified assumptions" (p. 215 & 217). Rothman (1989), a sociologist, embeds the descriptors in an ideological perspective:

> The very word midwife means with the woman...[This] represents a rejection of the artificial dualisms of patriarchal and technological ideologies...What midwives offer us is an alternative ideological base, and consequently the potential for developing an alternative body of knowledge about procreation. (p.170-171)

The midwife's alternative response to maternity health care is further emphasized by De Vries (1989), also a sociologist. He confirms that the differing styles of care given by the various caregivers may be directly influenced by the individual's motivations for choosing that career:

> A variety of factors causes an individual to choose a career in caregiving. These motivational factors determine the type of training that is sought and the style with which that training is applied. For example, the style of care offered by a woman who chose to become a midwife after an unpleasant hospital birth will differ from the style of care given by an obstetrician who chose his specialty as a fourth-year medical student after concluding that his first choice, surgery, was too bloody and too depressing. (p. 147)

Again, we see the emphasis on the midwife's independence in her choice to highlight the interconnectedness in the process of procreation and to reject the "patriarchal and technological ideologies" of traditional obstetrics.

Research Regarding Midwives and Midwifery

The majority of research into midwifery practice has focused on outcomes. As noted previously, morbidity and mortality statistics clearly demonstrate that midwife-attended homebirths are as successful as physician-directed hospital births, and according to some studies superior.

While this factor has a bearing on the current project, it is not the central theme, but rather an indicator of the need for this study.

Recently, several researchers examined the practice of nurse-midwives in the U.S.. Thompson, Oakely, Burke, Jay and Conklin (1989) proposed a middle-range theory of midwifery care in an effort to identify "what it is about the way nurse-midwives care for women that might contribute to healthy outcomes for women and infants" (p.120). The six concepts which they extracted from their observations were that midwifery care is safe, satisfying, respecting of human dignity and self-determination, respecting of ethnic and cultural diversity, family-centred, and health-promoting. Lehrman (1981) identified components of ante-partum and intra-partum care which she eventually incorporated into a midwifery practice model. These components are continuity of care, family centred care, education and counselling as part of care, non-interventionist care, participative care, consumer advocacy, time and flexibility. Morten et al (1991) extended this model into the post-partum period: their data generated the additional categories of therapeutic techniques, lateral relationship and empowerment.

Bassett-Smith (1988) studied the practice of midwives in New Zealand. She identified the process of **authenticating the experience of childbirth** as the core definer of midwifery care. Authenticating is described as multi-faceted and involving the four intertwined phases of making sense, reframing, balancing, and mutually engaging. It is interesting to note that the midwives in this study were not engaged in autonomous practice, and that the persistent theme of self-reliance and independence was not accented in this study. The primacy of inter-relationship is, however, very clear in this group.

The definition of distinct practice methodologies both within and between groups of midwives confirms the suggestion that midwives constitute an identifiable group, and supports the notion that an identifiable process of becoming a midwife takes place. It is clear from the sparseness of the research that the nature of this process has been minimally investigated, and yet it is also clear that the process of becoming plays a pivotal role in professional practice and thereby in the outcomes of that practice. Together, these factors corroborate the importance of carrying out research on this phenomenon. The unique nature and temporal finiteness of this population of independent midwives in Alberta affirms their importance as **subjects** of that research.

Pivotal to this investigation is an understanding of the concept "becoming", both linguistically and sociologically. What does becoming mean? How does one become? Knowledge of the implications and constituents of this concept will sensitize the researcher to the appearance of the defining attributes of the process, and thereby contribute to the thoroughness and trustworthiness of the data analysis. A concept analysis of "becoming" will now be presented.

Becoming: Analysis of the Concept

Walker and Avant (1988) suggest that concept analysis is an excellent first step in the development of theory. They state that "the results yield to the theorist or investigator a basic understanding of the underlying attributes of the concepts" (p.36). Strauss and Corbin (1990) advocate the development of "theoretical sensitivity" to the subject to be investigated. They define theoretical sensitivity as "the ability to recognize what is important in the data and give it meaning" (p.46). They advocate immersion in the literature and analytic processes as two avenues for its development, both of which are integral components of concept analysis.

The term becoming is used in the nursing and midwifery literature in a variety of ways, but is rarely explicitly defined or explained. However, it is pivotal to the topic presently under investigation, "becoming a midwife". On superficial reading, the meaning of this construct seems clear, but on careful analysis, many questions emerge, such as: Is this a process or an event? What is the difference between this term and other related terms such as transforming, or converting? Are there different degrees of becoming?

The aim of this exercise was to understand the range of meanings and defining attributes that the term "becoming" could assume, and to clarify how it might emerge in the proposed research. It was expected that it would indeed enhance the researcher's ability to understand the phenomenon and interact with the data.

Uses of the Concept

Dictionary Definitions and Origins

The Oxford Dictionary of the English Language (2nd ed., 1987; unless otherwise noted, all references and quotations in this section are from pp. 43 & 44 of this dictionary) identifies be, come and become as the root words of becoming. Early definitions reflect the sense of becoming as something which is attractive or appropriate. Although it is probably not the more common usage of this term at the present time, it is important to keep it in mind, for it may have implications for the more subtle defining attributes of the concept, which will be discussed later.

It was in 1853 that becoming first appeared in the literature as it is more commonly used now, when Robertson, in his Sermons, said "Everything is in a state of becoming, God is in a state of Being". Soon following, in 1860, Pusey, in his book The Minor Prophets, stated "Our life is a 'becoming' rather than a simple 'being.'" These usages of the term illustrate the definition of becoming as "a coming to be, a passing into a state." Careful examination of the various root definitions suggests that a sense of existence is contributed by the prefix be-, and a sense of movement or appropriateness is derived from the word come. The suffix -ing provides a sense of the art or action of this taking place, and of it taking place in the present.

Use in the Nursing Literature

Use in the nursing literature is overwhelmingly in the 'movement' rather than 'appropriate' or 'attractive' vein. It can further be arranged in three broad categories, which vary along significance and passive/active parameters.

In the first category, becoming is used in its most passive sense--more as a connector between two more important and active words. It is in this sense that it is used in a report in the Harvard Medical School Health Letter (1990) when it is said, "First time mothers are becoming an increasingly older group..." (p.7). The connection in the report is between first-time mothers and age: although a trend is mentioned, it is of less significance than these factors. Often in this usage, the activity applies to an inanimate object, as in 'the weather is becoming cold.'

In the second category, becoming is more active, and usually involves some form of life, condition or status change. There is often a process described, by which this becoming is brought about. It is in this sense that Turner (1988) uses the concept in her article "Motivation: Becoming a cheerleader for yourself, your profession." The steps in this process are explicitly described, and the changes in condition of both the individual and the group which emerge from the process are listed.

The third category of use for becoming is the most inclusive. Indeed, it is a descriptor of the human condition. It is in this way that Parse (1981) intends the term to be understood when she includes it in the name of her theory of nursing: Man-Living-Health: A Theory of Human Becoming. In this sense, becoming is indicative of a process of negentropic change, which permeates and cloaks every facet of human existence. This usage of the term is very similar to the way it originally appeared in print in the 'movement' sense.

Although this brief overview is by no means indicative of the wide usage of this concept (it is most certainly found in literature other than nursing), it does represent the realms of meaning that this writer was able to identify. Sensitivity to the fact that a process of becoming can assume greater or lesser degrees of centrality in the individual undergoing a process of becoming will sensitize the researcher to the degree of centrality of the process of becoming a midwife in the informants lives.

Defining Attributes

In order to be fully defining of the concept becoming, an instance must possess the following attributes, as gleaned from the definitions:

1. A sense of movement or progression.
2. This progression is from an actual state or condition to a different potential state or condition.
3. There is a process involved, which may be external to and/or internal to the subject of the becoming.
4. There is an element of time.

The sense of movement or progression may be manifested as, for example, advancement, growth, change, development, maturation, or deterioration. There is more often a positive affect than negative, but this is not necessarily so. This attribute is well portrayed in Vance's 1985 article On Becoming A Professional: "The aim is to help them become aware of the importance of their work to society, their potential to practice, and to find their place in a developing profession" (p. 20). In the present research, it will have to be asked whether there is progression or movement inherent in the change from "not a midwife" to "midwife".

The progression from an actual towards a potential state illustrates the fact that while one is in the process of becoming, one has not yet fully achieved that state. It is sensitively portrayed in Williams' (1987) account of Becoming a Woman: The Girl Who is Mentally Retarded. Using an ethnographic study, she describes the feelings, physical changes, attitudes and questions that both indicate and result from the adolescent mentally retarded girl's emergence into womanhood. In the proposed research, it will be necessary to explicate both which state the individual leaves to enter the process of becoming a midwife, and what the state is that she attains. For example, it will be important to ask what the state "a midwife" is and who decides what it is.

The third defining attribute, the involvement of process is well illustrated by Lemmer's 1987 article Becoming a Father: A Review of Nursing Research on Expectant Fatherhood. Following a review of past research, which is in itself revealing, she concludes that "Becoming a father is a developmental process of reordering roles and relationships" (p.271). In the present research, it will be important to identify the steps, environment and strategies that are involved in the process of becoming a midwife in Alberta.

The final defining attribute is that of taking place over time. It is beautifully described by Messner (1987) when she quotes from The Velveteen Rabbit (Williams, 1981):

> 'It doesn't happen all at once,' said the Skin Horse. 'You become. It takes a long time. That's why it doesn't often happen to people who break easily, or have sharp edges, or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby' (p.66).

In the present research, it will be important to determine the time involved, and the factors that impinge on the amount of time required to become a midwife in Alberta, and the relative centrality of time in that process.

Combining these defining attributes, becoming can be defined as a movement through a process from an actual state or condition towards a potential state or condition over time. Though not nearly as poetic, this sounds very close to the dictionary definition of "a coming to be."

Antecedents and Consequences

The next step of concept analysis is to identify the circumstances or events which precede the manifestation of the concept, and those conditions which follow it: the antecedents and consequences. For becoming, several antecedents are particularly crucial:

1. There must be an actual state from which to change. This may, as in the case of "becoming real" be a non-state, such as not-real.

2. There must be a potential for the movement to take place. For example, one cannot participate in "becoming real" if that is not within the realm of possibilities.

3. There must be a stimulus which begins the process. In the example above, a toy needed to be loved.

The single identifiable consequence of becoming clearly follows both the antecedents and the attributes of the concept: the subject of the becoming is in a different state or condition than he was before.

Empirical Referents

The final step in the process of concept analysis is to define those measurable components which indicate that the concept is present or has occurred: the empirical referents. For becoming, the single empirical referent would be that there has been some measurable change over time. Of course, the ease and preciseness of this measurement would be highly individual, according to the subject and object of this becoming. Therefore, it is easy to measure "the weather is becoming colder," but it is not so simple or precise to measure "George is becoming a father." It will be necessary to determine what empirical referents measured the process of becoming a midwife, where they came from, and who assessed them.

This exercise clarified the potential meanings of the term "becoming", and prepared the way for the investigation of its actual manifestation in the process "becoming a midwife". A second body of research and theory also addresses the notion of "becoming"--that of sociology. A brief review of that literature and the theoretical relationship with the current project will now be presented.

Sociological Literature and Theory

The process by which one becomes a member of an occupational group is addressed in theories of professional socialization. Professional socialization can be defined as "the process by which a person acquires the knowledge, skill, and sense of occupational identity characteristic of a professional" (Jacox, 1978; p. 10). Throwe and Fought (1987) elaborate on the definition to include "(1) the development of identity and projection of self worth; (2) acquisition of new knowledge, attitudes and skills: (3) interaction with others who emulate the role; (4) assessment of others' reactions to the role; and (5) preparation for future role enactment" (p.15).

Application of theories of professional socialization to the process of becoming a midwife in this study population presented several dilemmas. First, there is the question of whether midwifery generally is a profession, and, if so, whether those women engaged in practice during the study period were midwives in the full professional sense. The hallmarks of a profession include (1) autonomy, (2) specialized and extensive education, and (3) service orientation (Jacox, 1978). Although the definition of a midwife drafted by the World Health Organization (WHO) in 1972 (Sweet, 1988) can be understood to encompass these descriptors, midwifery education in Canada was not "duly recognized" nor was there an opportunity for "licensing and/or registration" (p. 3) during the study period.

Second, professional socialization suggests the existence of an established core of members, whom the novice can emulate, as well as a group of peers who provide support and feedback. The virtual absence of practising, independent midwives in Alberta at the outset of the study period assures the impossibility of meeting this requirement.

Third, the process of professional socialization is usually associated with some kind of formal organization or institution (Bucher & Stelling, 1977). The Alberta Association of Midwives, which was established following the 1982 recommendation of the Health Disciplines Board (Relyea, 1992), is at present primarily a political and representative body for its members. Unlike other professional associations, it has no regulatory function or legislative recognition.

These three factors prohibit the designation of the subject under study as "professional socialization". It was therefore inappropriate to impose such a framework on the process which was being explored in this project.

Broad general theories of socialization and role attainment proved more useful. Two major branches of socialization theory are the social structural view (also referred to as the functionalist view) and symbolic interactionism. The former view holds that roles are relatively fixed positions within society, are associated with expectations and demands, and are enforced by negative and/or positive sanctions. This is a relatively rigid perspective, which allows very little room for individual alteration of societal patterns of behaviour (Conway, 1988).

In the symbolic interactionist view, conversely, it is thought that the institutions in society provide a framework within which each individual actor constructs or organizes social action. These actions are, in effect, a response to the individual's interpretation of the meaning of the symbolic acts of others (Conway, 1988). To the symbolic interactionist, the individual is an acting being, whose concept of self and ability to interact with that self is the basis for his interaction with the world. In addition, symbolic interactionism "is an approach to the study of human conduct and human group life" (Chenitz & Swanson, 1986; p. 4) and forms the basis for the "grounded theory" research methodology (Hardy & Hardy, 1988). The symbolic interactionist perspective, with its emphasis on meaning, flexibility and the active nature of individuals, is particularly amenable to the current study, which seeks to trace the development of a new sense of self in the informants. It was therefore the theoretical approach which was used to guide the research, in both methodology and analysis.

CHAPTER III - METHODS

Project Framework

When there is very little existing research into a topic of study, the investigator should approach the subject area from a very broad, open framework. This ensures the emergence of an abundance of data, making a wide range of observations and experiences available for examination and analysis. The qualitative grounded theory approach first developed by Glaser and Strauss (1967), and further described by Strauss and Corbin (1990), was selected for this project, both because of its emergence from and synchrony with the theory of symbolic interactionism, and because it seemed particularly well suited to the nature of this research. Grounded theory is an approach specifically designed to blend creativity and inclusivity with the disciplines of analysis and organization. It directs the organization of a diffuse body of information into a theory about a process which may then be related to or compared to other theories. The specific processes of this methodology will be described in the associated research steps as they occurred in this particular project.

Definition of Terms and Criteria for Inclusion

As was mentioned earlier, the international definition of a midwife did not apply to this group. Indeed, one of the descriptors of this group of midwives was the assumption of the midwifery role prior to the establishment of standards and regulation. However, the international definition was used to distinguish this group from those who had midwifery education and certification from another country, but were employed in a nursing capacity: only those practitioners who had been carrying out (or planned to upon completion of their program) the full role of the midwife were accepted into the study. Therefore, the inclusion criteria were as follows:

1. The individual must have provided independent midwifery care at any time

in the period 1970 to the present.

2. To be considered "independent midwifery care", the individual's practice was required to demonstrate the inclusion of the descriptors "the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant" (Sweet, 1988; p.3).

3. Those students who were included in the study were required to show evidence that at the completion of their formal or informal program they planned to participate in midwifery practice as defined above. Affiliation with independent midwifery practitioners during their educational program was the usual means of providing this evidence.

4. Because there have been various routes of entry into midwifery practice, inclusion was not restricted to those with a recognized certificate from a foreign country.

5. Because there may have been independent midwives practising in various distinct cultural groups (eg. Hutterites, Native communities), and because these practices were likely qualitatively distinct, only those offering services in the dominant culture were included.

6. The actual process of becoming a midwife was required to be embedded in the Alberta context. Those who were residents of a foreign country, became a midwife there, and later came to Alberta and practised independent midwifery were excluded. Included were those who left Alberta to seek education elsewhere, and subsequently returned to practice, and those who came from another part of Canada to pursue midwifery in Alberta, and subsequently practice or intended to practice here.

7. Because the researcher intended to examine the population engaged in independent midwifery practice, with its attendant risks and challenges, those who practice in demonstration projects, in which there is an inherent degree of supervision, were not included.

Inclusion of informants at various points of the process helped to determine if there was any variation and transformation over time. Inclusion of informants from differing professional entry programs (eg. nursing, nursing and midwifery, apprenticeship) helped to determine whether there are commonalities across all midwives, and what, if any, differences exist. As is common in all qualitative research, selection criteria included the ability and willingness to speak about the topic under study (Morse, 1991).

Sample Recruitment

Since this was a beginning study of the phenomenon, and the population was very small, an attempt was made to access all members of the population. Those members of the population not already known to the researcher were reached through referral by those who were. Informants were invited by letter and follow-up telephone call to participate in the project (See Appendix A, p. 161, Appendix B, p. 162, and Appendix C, p. 163).

In total, fourteen possible informants were identified and invited to participate in the study. Of these, twelve consented, and nine were actually interviewed, owing to the difficulty of making and keeping appointments. Indeed, the data collected from the nine informants was considered sufficient for the development of a theory. A full description of the informants is included in Chapter IV, Findings.

Data Collection

Data collection took the form of a single semi-structured interview. This interview followed the directives implicit in Kvale's (1984) description of the qualitative research interview:

> It is: 1) centred on the interviewee's life-world; 2) seeks to understand the meaning of the phenomena in his [sic] life world; it is 3) qualitative, 4) descriptive, and 5) specific; it is 6) presuppositionless; it is 7) focused on certain themes; it is open for 8) ambiguities, and 9) changes; it depends upon the 10) sensitivity of the interviewer; it takes place in 11) an interpersonal interaction, and it may be 12) a positive experience (p. 174).

Due to the transient, historical nature of this population, and its small size, the time frame was both retrospective and concurrent. In other words, those at various points in the process at the time were interviewed, as well as those who had experienced the process in the past.

A pre-determined list of possible questions acted as a resource for each interview (see Appendix D, p. 164). In the nature of qualitative research interviews, these questions changed as indicated by past interviews and according to the dynamics within each interview. Generally, the initial questions were broad and open, and aimed to elicit the informants' perspective on the subject. The follow-up questions were more specific, and were used to focus attention or to explore innuendo. The interview was semi-structured by virtue of the fact that the questions were not necessarily all used, and were individualized according to the dynamics of each interaction. The questions also changed according to ongoing and concurrent analysis, which suggested new areas of exploration and indicated inappropriateness of initial areas of study. As the data base developed, subject areas with minimal information often became the focus of increased attention.

Although it was expected that each interview would last no more than one hour, they actually ranged from one-half hour to as much as two and one-half hours. No repeat interviews were scheduled. Reviews of the transcribed interviews were made available to the informants. Only one informant asked to review her transcript, but no changes or deletions were solicited or made. The interviews were audio-taped with the full knowledge of the interviewee, and were transcribed verbatim, except where names are used: those were erased. Non-verbal elements and/or subjective impressions, or field notes, were recorded by the researcher following each session.

At the interview, biographic data was obtained from each of the participants (see Appendix E, p. 165). Besides that which is purely descriptive (age, marital status, education), the information elicited was that which the literature review suggested may be relevant to the process, and which will be beneficial to have recorded in an easily recoverable form. Personal child-bearing history was included because De Vries (1989) suggested that it may influence the type of educational program chosen. Educational and professional backgrounds were included to help determine informants' temporal relationship to the process, and to record antecedent and subsequent professional associations and occupation.

Pilot Interview

A pilot interview was carried out, with the intent of sensitizing the researcher to the data, and to test the interview format. This interview was carried out with a midwife who did not fit the inclusion criteria, and of itself did not become part of the data.

During this interview, it was suggested that the relationship between the midwife and her client was qualitatively different than that between other health professionals and their clients, and that the realization of this difference was inextricably bound with the process of becoming a midwife. As a result of this finding, the study informants were given the opportunity at the outset of the interviews to speak about their view of what a midwife was, and to describe the midwife-client relationship--how it differed from other relationships, and if it was important. It was surmised that dwelling on the nature of midwifery at the outset of the interview might direct the informants' attention to the process by which they had come to be or were coming to be this kind of a person.

Not all informants chose this option. Several elected to begin by simply telling the story of how they came to be a midwife. However, all the informants did eventually share some views of the defining attributes.

Data Analysis

The transformation of this data from its raw form to presentation in an organized, succinct theory took place according to several well-defined antecedents and processes in the grounded theory methodology. Each of these will be explained individually.

Theoretical sensitivity.

An important antecedent and concurrent attribute of the researcher is that of theoretical sensitivity. Theoretical sensitivity is that quality which enables the analyst to "see" with analytic depth what is there. It is initially promoted through the researcher's pre-existing familiarity with the research topic (many researchers study areas in which they already have some interest or knowledge) and through investigation of the technical and non-technical literature available in the general area. Judicious use of concept analysis (Walker & Avant, 1988) can also enhance theoretic sensitivity. Extensive immersion in the existing knowledge is not recommended, since it can blind the researcher to new information which is appearing in the data.

With regards to the present study, the researcher had familiarity with the topic by virtue of the fact that she was a midwifery student. Sensitivity was further enhanced by a limited literature review of professional socialization, particularly as it relates to medicine, nursing and midwifery, and of various aspects of the practice of midwifery, a portion of which is related in the foregoing rationale. A concept analysis of the term "becoming" was also carried out.

The concurrent development of theoretical sensitivity occurs during the process of analysis, particularly when there is a need to go beyond superficial and established modes of thinking about the topic and data. It is carried out by the use of questioning (Who? What? Why? How much?), analysis of a single word (such as becoming), comparisons (to the exact opposite phenomenon, of two or more phenomena, or to an extreme manifestation of the phenomenon) and by marking those words and phrases in which there is an element of absolutism (never, always, everyone).

Open coding

The initial activity carried out on the data was that of open coding. The transcribed data was looked at line by line, and each concept was identified with a label. This process was facilitated with the use of questions (what is going on here?) and by making comparisons (as above). These concepts were further grouped into categories. These categories were given names which readily relate the properties and dimensions of a group of concepts. A record was maintained of this classification of concepts and categories.

Axial coding

At this level of analysis, the researcher began to "put the data back together". Categories were related to one another and to the environment from which they emerged (sub-categories). This function was carried out alternately with open coding, in such a way that it may appear that the two were happening simultaneously. They are, however, two distinct procedures, and the researcher kept their different specifications well in mind.

The sub-categories were related to the larger category according to a paradigm model:

(A) CAUSAL CONDITIONS --- (B) PHENOMENON---
(C) CONTEXT --- (D) INTERVENING CONDITIONS---
(E) ACTION/INTERACTION STRATEGIES---
(F) CONSEQUENCES (Strauss & Corbin, 1990, p. 99)

In this way causal relationships began to emerge.

The process by which this analysis took place can be divided into three steps. First, the researcher hypothetically related the subcategory to the larger category by means of relational statements. Second, the resulting hypotheses were verified against actual data. Third, the simultaneous searching for different properties, for sub-categories and categories, and for their dimensions continued. Fourth, the researcher began an exploration for variation in phenomena. This process was facilitated by maintaining awareness of the subtle variations and complexity which appeared in the data, and of the need for both inductive and deductive mental faculties in the analytic procedure. Once again, a record was maintained of this process.

Selective (theoretical) coding

In the final step of the analytic process, all categories were related to one another, and a core category emerged, to which all other categories were subsidiary. From this arrangement a story line was drawn, delineating the process which was common to all informants. It represents the process at its highest level of abstraction, and gives a sense of order and causality. This arrangement constitutes the theory which is the product of all these efforts.

Memos and diagrams

Throughout the analysis, the researcher made liberal use of memos and diagrams to assist the coding processes. As mentioned previously, records were kept of the categories and their relationships to one another and to concepts and sub-categories. The vast numbers of these elements made them quite unwieldy, and their arrangement into a visual relationship was an important means for the researcher to identify the underlying connections. Maintaining all thoughts and ideas in a written form was absolutely imperative, for the same reason, and to ensure a permanent record of the analysis.

These elements constitute the major components of the grounded theory methodology, which was used to guide this research, and brought about the theory which will be presented in the forthcoming chapters.

Reliability and Validity

Since the purposes of qualitative research are very different from that of quantitative research, it is difficult, if not counter-productive, to apply the usual standards of reliability and validity to this type of study. However, it was important to identify standards of rigor for any type of research: it is helpful be able to evaluate the degree to which a study can be believed, and can be generalized to other situations. In this project, the standard of trustworthiness, as described by Guba (1981, quoted in and interpreted by Krefting, 1991) specifically for qualitative studies, was utilized.

Guba redefined the qualities of internal validity, external validity, reliability and objectivity in terms of the underlying values reflected in each, then reapplied them to the qualitative paradigm. Each will be described individually, as they were used in this project.

Credibility (Truth value, Internal validity)

The credibility of a study is the degree to which the findings accurately reflect the "human experiences as they are lived and perceived by informants" (Krefting, 1991, p. 215). The standard to which one aspires is that of instant recognition by readers with similar experiences. There are several strategies which have been described and were used to assure this quality:

1. Prolonged engagement: Longer periods of exposure to informants increases the sensitivity of the researcher, and her ability to elicit trust. In the study, interviews were lengthy (as much as two and one-half hours), and liberal amounts of time were spent becoming comfortable before and after the actual interview. The researcher's familiarity with the subject area, and indeed with many of the informants, was observed to promote credibility.

2. Time-sampling: Gathering information at different stages of the process under study increases credibility. In the present study this condition was realized by interviewing informants at different points in the process of becoming a midwife: students, new midwives, and those who had been midwives for many years.

3. Reflexive analysis: In qualitative studies the researcher is considered a participant rather than an observer, and her own experience may become enmeshed with the process and the data. This was certainly the case in the present research, both due to the fact that the researcher was in fact in the

described process when she was carrying out the research, and due to sensitivity and intimacy of the subject matter. Many of the informants came to this journey from devastating and/or inexpressibly empowering experiences related to birth, sexuality and their experiences of being female. While the researcher's subjective involvement on the one hand significantly augmented the quality and quantity of the data as well as her sensitivity to that data, at various points it is also critical to be able to "stand outside" the process and data. This was facilitated by the keeping of a personal journal, in which the researcher's feelings and thoughts regarding both the research process and the process of becoming a midwife was recorded. The researcher's colleagues both in graduate study and in midwifery were an indispensable resource and source of support in the understanding and resolution of the subjective experiences that emerged, and enabled her to eventually find a place for them. This often involved an acceptance of a myriad intense emotions and simply working through them to their natural resolution.

4. Member checking: If the emerging coding categories reflect the essence of an experience, then any member of the study sample should be able to verify the credibility of these data. This activity was carried out in several ways. First, allusion to emerging categories was deliberately but subtly incorporated into subsequent interviews. Second, presentation of preliminary research results at various conferences and meetings yielded spontaneous responses of familiarity and recognition from people who were actively involved in the process, but did not meet the inclusion criteria at the time of data collection. Third, informal but deliberate consultations with informants at various points in the analytic process took place. Fourth, terminal checks from each informant were solicited. Of these terminal checks, several informants verbally indicated familiarity with the data and process. One informant shared that any of the informants' stories could have been her own, and that once having begun reading the report, she was unable to put it down, due to her depth of identification with the findings and her emotional response to them.

5. Peer examination: This strategy is based on the same principle as member-checking. In this study the supervisor was intimately involved with the data analysis. A graduate student from a distinct faculty also contributed crucial input to the analytic process.

6. Interview process: The skilled utilization of the techniques of the research interview enhance the credibility of the informant's responses. In this study this skill was enhanced through peer and supervisor review of interviews. A pilot interview was carried out, the effect of which was reported previously. In addition to evaluating the appropriateness of the research questions, it helped to estimate time requirements and to highlight shortcomings in the researcher's technique. Transcription of all interviews by the researcher also had a significant effect on subsequent interviews.

7. Structural coherence: It is important to ascertain that all data are incorporated into the final structure, even those data which are divergent from the norm. This strategy was encouraged through the use of peer review, member checking, and the researcher's personal vigilance.

8. Authority of the researcher: Krefting (1991) states that "the essence of the credibility issue is the authority of the researcher" (p.220). In this study, the supervisor's past experience with qualitative research and the researcher's and supervisor's familiarity with the topic under study should establish without reservation the skill and credibility of the investigators.

Transferability (Applicability, External validity)

Traditionally, the transferability of a study is the extent to which the findings can be generalized to the larger group. Typically, this is not a goal of qualitative studies, particularly when the group is unique in both time and circumstances, which is the case here. Of greater importance is the certainty that the study environment and procedures are adequately described should comparisons be attempted to similar situations in the future. Being that one of the purposes of this study is a possible longitudinal follow-through, this standard was sought to be actively maintained and assured through peer (particularly committee) review.

Dependability (Consistency, Reliability)

The standard of consistency refers to the assurance that similar structures would be developed by other researchers or by the same researcher at a different time, given the same conditions. Though the value of the uniqueness of each particular research process is acknowledged, and indeed promoted, a degree of dependability was indeed sought. First, it is facilitated by the dense description of research methods in the final report. Second, it was be promoted through the utilization of a code-recode procedure, in which the researcher coded a segment of data, waited a period of time, coded the same data, and then compared the results. Generally, consistency over time was found in this exercise.

Confirmability (Neutrality, Objectivity)

The standard of confirmability refers to the degree of correspondence between the data and the interpretation: that is, that the two follow one another and were not the creation of the investigator. Confirmability was ascertained through concurrent audits by the supervisor and informants.

Ethical Considerations

The ethical principles which guided this research were derived from the Kantian imperative to maintain "respect for individual autonomy based on the fundamental principle that persons always be treated as ends in themselves, never merely as means" (Cassell, 1980, p. 32). Cassell (1980) has explored the implications of this philosophical attitude as it relates to qualitative research. The various suggestions which emerged were incorporated into the ethical standards which were applied to this study.

Lateral Relationship

A major ethical dilemma arises when the researcher is in an unequal power relationship to the informant: the possibility of coercion or the inappropriate use of confidential data may necessitate the incorporation of complicated and elegant strategies of maintaining distance and anonymity (Frisch, Fowler-Graham, Shannon & Dembeck, 1990). In the present study the researcher was in a lateral relationship with all informants: all were autonomous colleagues who were not and will not be dependent on the researcher in any way.

Segregation of the Research Interview

Cassell (1990) asserts that "ethnographers frequently become honourary or symbolic members of the community and friends with many of their hosts, who then tend to "forget" that they are being studied." (p. 35). Considering that the researcher was well acquainted with most of the informants prior to the project, and became more so through the process, this was an issue of some concern. Of necessity, trust in the segregation of the research and social relationships is dependant at least in part on the integrity of the researcher: a standard which was, hopefully, established in prior acquaintance with the researcher, and should have been ascertained by the informants' voluntary entry into the study. A second, more tangible protection was the clear demarcation of research interviews: only those interactions which were audio-taped were retained for data analysis (see Information Sheet, Appendix C, p. 163 and Consent, Appendix F, p. 166). Continuous surveillance was exercised by the researcher to maintain segregation of interactions which involve the informants as informants as contrasted with informants as friends and colleagues. Complete compartmentalization was not possible, and acceptance of this fact is implicit in the informed consent by the informants following explicit, candid disclosure by the researcher.

Confidentiality of the Identity of the Informants

A more significant source of harm to the informants may be the invasion of their privacy and their vulnerable exposure to those persons in positions of power by virtue of publication or availability of the data. For example, it is conceivable that criticism of other health professionals or institutions could instigate a negative response. Several factors and activities have a bearing on this issue.

First, there is always a balance which is sought in this type of interaction: the potential benefit should outweigh the potential harm. It was expected that the opportunity for the informants to tell their story would be more valued than the risks incurred. There is also the potential for greater positive recognition and autonomy of the profession of midwifery by virtue of the research. Such an outcome is compared by Cassell to an advocacy program, and as such is "a paradigm of the ideal relation between investigators and subjects" (p. 37). The recognition of this trade-off and acceptance of the risks involved was implicit in the voluntary entry into the study and the provision of informed consent. The goals of the study were explicitly stated on both the information letter and the consent.

A second factor which affected the vulnerability of the informants was the fact that each had complete control over the information given in the research interview. The absence of any coercive potential in the relationship was supportive of this fact. Concurrent reviews of transcripts, if requested, and a terminal review of the research report by all informants, with the opportunity to exclude any data which was considered detrimental, was carried out.

A third factor would be the inclusion of current MN/CNM students at the University of Alberta, who could have been in a vulnerable position with regards to the researcher's supervisor. However, there were no students at the time of data collection who fit the inclusion criteria, and hence none were included.

The obvious benefits which may be derived from participation were balanced by explicit protective activities. All demographic data in the report were kept separate from the study results, other than when biographics are explanatory, and then only with the consent of the informant, as ascertained at terminal checks. An attempt was made to not use names or identifying information on the audio-tapes, and those that did appear were not transcribed. Names, biographic data, and interview data were kept in separate locked compartments. Access to this material by individuals other than the researcher was and will be denied. All data will be kept for the period of time required by the institution with which the investigator is affiliated: at present seven years. Transcribed interviews and biographic data may be made available for secondary analysis by other researchers or the present researcher, conditional upon ethical clearance by an ethics committee, and the explicit consent of one particular informant, who requested the same.

Provision of Informed, Voluntary Consent

As noted in the invitational/information letter (see Appendix A, p. 161 and Appendix C, p. 163), the informants had several opportunities to enter and decline to enter the study. As noted by Cassell (1980), the intent is often as important in the procurement of informed, voluntary consent as are externally imposed controls. Intent on the part of this researcher could be inferred from her description of the various elements involved in the process, and her stated intention to avoid any sense of coercion in all relationships.

Prior to initiating the interview, the informants were asked to reread the information letter, and were given the opportunity to pose further questions. If they remained willing to act as informants, they were asked to read and sign the consent. Copies of the consent and information letter were left in their possession.

The background, strategies and reasons for carrying out this research have been described. In the following chapter, the **findings** of these activities will be shared.

CHAPTER IV - RESEARCH FINDINGS

INTRODUCTION

The initial research question, "What is the process through which a woman moves as she changes from regarding herself as not a midwife to a midwife?", remained unchanged throughout the research process. The findings which respond to this question will be presented in three major groupings. First, the numerical and demographic data which succinctly describe the informants and their education will be advanced. Second, a description of the findings from the data will be outlined, as grouped under two major headings: the informants' definition of a midwife, and the process by which they came to be, or were coming to be, that person in their definition. Third, the synthesis of the descriptive data into a cogent, grounded theory of how these informants became midwives in Alberta prior to regulation will be put forward. Relation of these findings to research and other literature will take place in Chapter Five.

THE INFORMANTS AND THEIR EDUCATION

The descriptive data presented here was drawn from the questionnaires which the informants were asked to complete at the outset of the interview (see Appendix E, p. 165). As will become clear, not all information solicited will be presented here. Official marital status, for example, was regarded by some informants as being rather intrusive, and to have little bearing on their learning to become a midwife, and thus will not be included in demographic descriptors. Instead, the involvement and significance of partners as it emerged in the informants' stories will be included in the appropriate section.

The informants were nine women who matched the criteria for participation in the study. Seven had practised or were practising midwifery in Alberta at the time of their interview, and two were still in the process of becoming a midwife. Their pseudonyms, the majority of which were chosen by the women themselves, are:

Emma
Alana
Patricia
Jean
Lynn
Leslie
Frances
Irene
Ruth

Characteristics of the Informants

The mean age at which the informants intentionally began pursuing education in midwifery was 27 years, with a range from 20 to 34 years. Their mean age at emergence as an independent midwife (of the seven who had actually completed) was 29, with a range from 25 to 36 years. Personal child-bearing history was considered by several to be meaningful to the process, and therefore a brief numerical synopsis will be presented here, and the full relationship will be explored in the appropriate section to follow. Five women were nulliparous at the time they began education for midwifery, and of those, three were nulliparous at completion. Twelve births were distributed among the remaining six informants. Of the 7 that occurred prior to the beginning of their education, 5 were in hospital, and 2 were at home. Of the 5 that took place during their learning period, 2 were in hospital and three were at home.

Characteristics of the Education

The participants in the study utilized a great variety of resources in their education. This diversity will be fully explored in the ensuing portions of the report, and only major programs of study will be outlined here. These programs do not define the complete time frame within which learning, and therefore the process of becoming a midwife, took place: the numeric parameters presented here are indicative of only the **instructional** period. The narrative description of the process will clarify these various components of the becoming process.

The mean length of the process of becoming a midwife was 2.85 years, with a range of zero to six years. The first informant to explicitly begin her education for midwifery did so in 1973, the last in 1991. Of those who have completed, the first did so in 1975 and the last in 1991.

A variety and range of structured programs were accessed by the informants to procure their education for midwifery, the four main ones being nursing education, nursing post-basic education in midwifery or advanced obstetrical nursing, direct-entry midwifery education and apprenticeship. Often two or more of these programs were combined. The following list shows the numbers who utilized each:

Registered nurse training:	
Prior to decision to become a midwife:	3
For midwifery education:	3
Post-nursing or nurse-midwifery education:	
Prior to decision to become a midwife:	1
For midwifery education:	2
Direct entry midwifery education:	1
Apprenticeship:	7

These numbers do not convey the education which all the informants had at the time of interview: many proceeded to pursue various routes of further education **following** their emergence as independent midwives in a very similar manner to the way they and others had done within the becoming process.

This numerical overview presents a broad framework for visualizing the way that these nine women became or were becoming midwives in Alberta. Within this bare structure, the data reveals a fascinating and important process of becoming and change. These findings will now be explored.

DESCRIPTION OF FINDINGS FROM DATA

Definition of Midwifery

The informants were asked to share what they felt a midwife was, both to direct their thoughts to how they felt they were becoming one, and because the pilot interview suggested that this would be beneficial. These definitions proved to be remarkably consistent. In particular, the midwife-client relationship was viewed as an important defining attribute of midwifery care. Indeed, it was possible to draw a beginning model of the midwife-client relationship from the data. The significance of finding a consistent definition of midwifery within the data is that it supports the possibility that a common process of becoming a midwife can be discovered within this group. The specific aspects of this definition and relationship will now be explored.

A Midwife is Educated

The single unanimous descriptor that emerged was that a midwife is educated. Therefore, she "is a person [who] knows, understands, and has the skills and knowledge to work with a woman and her family throughout the childbearing cycle" (Patricia, lines 19-23). While dwelling on how a midwife is different from other important supportive individuals at a birth, Leslie observes that the difference is "less clear unless you bring in the things like education" (lines 43-44). This education can take many forms, all of which are acceptable. Jean states very succinctly that she thinks that "a midwife is a trained practitioner in whatever way she is trained, either by apprenticing, or just by experience, by education, who can guide a family to a normal birth" (lines 22-26). Indeed, the midwives felt that it was desirable and valuable that midwives be educated in a variety of ways, thereby honouring the diversity which potentially exists in the profession and is actually present among birthing women:

> Oh, I think ... there has to be a lot of different types of midwives, to begin with, because there's so many different types of women. I think that there's a real need for midwives who have a stronger technical, medically-oriented background, [who] would work well in [a] hospital, or birth-centre environment, and then you have to have probably the more home-grown version of the midwife who's willing to, to be in a home environment, more likely to use homeopathic or naturopathic treatments rather than relying on some of the medical technology, because I think the client base is that broad. (Alana, lines 23-36)

The informants mentioned specific elements that should be included in this education, particularly as it related to themselves. These will be fully described in the coming sections, as the delineation of the process of becoming a midwife unfolds.

A Midwife Specializes in Normal Birth.

Jean (above, lines 22-26) introduced the second important definer of the midwife, that her area of practice is normal birth, and makes special effort to protect the normalcy of birth. Irene observed that:

> I like these bumper stickers, [that] say, "Midwife, Guardian of Normal Birth." I mean, you're guarding, you just kind of sit there to keep an eye on it. (Lines 790-793)

This special effort was seen to stem from the midwife's attitude towards the birthing process. Frances explains:

> Midwives treat it as a normal process, and don't medicalize it, and make it into something that requires all the technology and emergency measures. (Lines 176-179)

Lynn also contrasted the midwifery approach to the medical approach to birth. She shared an analogy:

> I used to work as a rafting guide. And all the guys would do the big macho trick, and get tips. And I would never get tips. You know, because, I just showed them how easy it was to do, rather than having to play the big ego role, if it wasn't for me, we'd be in the water, you know, no. (Lines 1346-1351)

This analogy reflects the midwives' trust in the normal birthing process, their avoidance of centrality in the process, and their belief that with a measure of support and education, women are quite capable carrying out the birth without interference. This commitment was reinforced by Irene:

> But I still think that, if I don't have to use anything, that's the best way. The same thing with vitamins, and folic acid, and you name it....I always start asking people to eat first. Do you take care of yourself? And [we do] all that stuff first before I have to add artificial things....I mean, it's such a beautiful process, why would we have to add anything? I don't know, so I try not to add anything. Eat spinach and drink orange juice. Eat well, rest, visualize, relax, enjoy, you know, care for yourself. Care for yourself, that's how you care for your baby. (Lines 2169-2189)

Leslie felt that women need this trusting perspective from their caregiver:

> We need, as women, to have people who have confidence and trust in our--both in our abilities to do those things, and also in ourselves. Like not, it's not just something that's okay, you have a uterus, and you have all those hormones, and therefore you should be able to do it. It's something that's more than that, that's more whole, more inner. Um, than just that kind of trust. (Line 63-72)

In summary, the informants felt that midwives should be educated in the field of normal birth, and should know the means and have the commitment to keep birth normal. A midwife's trust in the birthing process and conviction that her trust is significant are important components of this protection of normal birth. From this attitude and commitment flows the next defining attribute of midwives, their socio-political nature.

Being a Midwife Has Socio-political Implications

In her assertion that women needed a certain type of attitude and care, Leslie hinted at the socio-political nature of midwifery--that midwives seek to alter the position of women, and particularly birthing women, in this society. Indeed, several informants saw their position as midwife as enabling them to realize goals such as advocacy and socio-political change. Emma spoke of her changing sense of role:

> But now I have a vehicle to sort of work with that. So that I can work with ... a community that really supports ... women and children and, and husbands ... in the way that is necessary to maybe cause some change overall. (Lines 514-521)

Irene's identification with the advocacy role stemmed from her anger with and sense of betrayal by the existing system:

> And I somehow, I always felt, if there's somehow, how could I stop this, how could I ever do something for this not to happen to another woman. To be totally driven over and destroyed. And something said, "You become a midwife! You show these bastards that's not how you deal with it!" (Lines 250-257)

Indeed, Leslie observed the effect of this kind of advocacy for midwifery-attended women in the hospital:

> And, this midwife had gone and talked ahead of time with the doctor, and he actually, when this woman came in and said, "You don't have to do any of those things." And I thought, "So. Something makes a difference here. If there's somebody out there who cares about the woman, and what's happening, um, because there's an awful lot of women who came to that particular hospital who were very well educated, who had jobs where they were used to dealing with people of authority and many of them were professionals, and they [weren't] able to say to the doctor, "I don't want this."...And so I thought, "There's something different about having a midwife. It's not just the fact that she knows how to catch a baby...And it's not the fact that she's good labour support...There's something more to this." (Lines 548-572)

The far-reaching effects of a positive birth experience, and the impact that a midwife could have both individually and collectively was strongly felt by all the informants. On the other hand, they were also exquisitely sensitive to their precarious position as "allegal" practitioners in an unfriendly medico-legal environment. The positive effect of their work was seen to far outweigh these threats, however. The significance of this commitment was reflected in Alana's appreciative statement:

> I think I really appreciate the women that have been in this for years, and have been willing to work against the odds, you know, when there was no authorization, no legislation, when it was actually allegal, and they're still doing it, because of the importance that women have that choice. (Lines 1429-1436)

A Midwife is Autonomous

One significant definer of a midwife which was rarely explicitly referred to but was clearly a thread that ran through all the interviews, was the notion of professional autonomy. When describing an element of her interaction with a client, for example, Ruth mentioned independence as a necessary antecedent for the freedom to make decisions regarding the way she practised. Frances mentioned that because of her relative independence in the nursing positions she chose, her practice there did not differ significantly from her practice as a midwife. Other allusions such as these were embedded within the data, thereby supporting its inclusion as one of the definers of midwifery. It is also clear that other definers, such as the midwives' socio-political nature, could not be realized without autonomy. Moreover, autonomy is an essential precursor to the last important definer, that a midwife has a special relationship with her client, since without the freedom inherent in autonomy, she would not have the space necessary to develop such a full relationship with her client.

A Midwife has a Special Relationship with her Client

Consistently, what emerged as the hallmark of midwifery practice was the unique relationship which developed between the midwife and each individual client. Emma stated this beautifully as she connected this relationship to the meaning of the word midwife, with woman:

> But those are all--that's almost all kind of peripheral stuff, as to what the core meaning of, I guess, to what all the books even identify as being a midwife is someone who is being with women, for women, and supportive of women in the process. (Lines 272-277)

Leslie conveyed a similar conviction when she tried to differentiate midwifery from other professions. First, she spoke of women being the focus of care:

> And then working with women and families and seeing women as being the centre of an experience rather than the professional...I think, that's one thing that makes us maybe different from other people who do similar kinds of work to us. (Lines 28-34)

She then went on to describe how this focus was reflected in a unique relationship:

> But that, I think, is all part of being a midwife, is um, is taking that extra step, and maybe that's a little bit too what makes us different from some of the other professions, is the willingness to go beyond just the professional kind of relationship where I'm the expert, and you're the person who's coming to me for my expertise, and my advice, and my knowledge. (Lines 87-96)

Frances spoke about the way the relationship was differentially expressed according to the degree to which she was familiar with her clients, and changed as she progressed towards practising autonomous midwifery:

> When we first started, we didn't know people as well as we do now, because we didn't do prenatal care, teach prenatal classes and stuff like that. But in the first couple of years that we were working with [the physician], I don't think I would have called myself a midwife. It was a process that was happening while we were working, and by the time I was calling myself a midwife, I would've said I was [as familiar with my clients as I am now]. (Lines 218-230)

These illustrations unequivocally express the significance of the midwife/woman relationship to the informants. A description of the entrance into this relationship, its major elements, and its outcomes will now be given.

Entering the Relationship

The relationship was entered into with intention and commitment, and with the full awareness on the part of both partners that this interface would be unique among care-giver/care-receiver interactions. Frances contrasted:

> Women don't really become friends with their obstetricians, and they don't see the nursing staff till they get to the hospital. Their midwife is somebody they shop around for, and spend a lot [of time] with, and so of course you develop close intimate relationships. (Lines 203-209)

Emma also talked about the midwife and client "venturing" into a relationship which is qualitatively different from that experienced between a doctor and patient:

> Generally speaking, this is a, a long relationship, that's nurtured and developed...on both parts. You know, both the midwife and the client are kind of venturing into a relationship. You know, not just a, sort of a--you know, a doctor-patient or a midwife-patient or client, or whichever words you want to attach to those. (Lines 73-80)

Leslie clearly spoke of a "willingness to commit" which she noticed in other midwives as well as in herself, and which is reciprocated by the client:

> ...to walk into a room, and just say, "Okay, you're doing fine," isn't enough to build that kind of trusting relationship. And so there has to be the willingness on the part of the midwife to take another step beyond just that professional part of the relationship. And there also has to be a willingness on the part of the woman to allow for that extra step to be taken. I think it's something

that's very reciprocal. (Lines 77-87)

As well as resulting from the intention and commitment, the midwives felt that this relationship was a natural outcome of the nature of the birthing process:

> I think because it's such a transition, pregnancy, labour, birth, motherhood, it's such a life change, and someone has been your partner through this, you know, and been your guide, and so, I think you're open to form a bond with that person. (Jean, lines 1017-1023)

These excerpts from data have conveyed the informant's perception of the conscious intent and commitment to establish a unique and important relationship on the part of both midwife and client. From this conscious beginning flows the **substance** of this relationship, which will be described next.

Major Elements of the Relationship

Once the step was taken to enter into the relationship, three major elements that the informants felt developed and maintained this special partnership were described. These were lateral construction, woman-centred perspective and time.

Lateral construction.

Classification of the relationship as laterally constructed is foreshadowed in its reciprocal beginnings. As the interaction progresses, laterality becomes evident in such elements as the assumption of power, decision making and the taking of responsibility. In Patricia's words,

> Well, it's a very special relationship...that hopefully is not hierarchical, in that the woman and her family will not feel somehow less than the midwife; that this midwife has special knowledge and skill, but it's more of a friendship that develops over a period of time. (Lines 39-47)

This construction portrays a sharp contrast to the hierarchical structure which the informants felt characterized the physician-patient relationship. In contrasting her learning in the medical environment to her learning in a midwifery environment, Leslie observed that

> You know, you go in there into the physician's office, and you have your lab coat on, and you'd have you stethoscope around your neck, and you're sort of putting on these airs, that aren't who you are. And, [there's] this real, almost fake division between the professional and the woman. And not being able to say that I could be that woman too. I could be the one lying on that bed. And it could be my experience too, and so why am I making myself as though I'm something other than a woman, or other than a person. That I'm this **thing** that's an expert. And, for me that seemed, the midwives, you know, just being able to feel comfortable talking about themselves as well. And that real sharing of who they are with the woman, and I think there's still always gonna be that sort of, it is an unbalanced relationship, because the women come to the midwife for a particular reason, and some of that has to do with the professional things, like knowledge and expertise. But, the gap is so much closer. You know, it's just, it's not something way far apart like that, it's really close. (Lines 1066-1092)

As these quotes clearly illustrate, the definition of the midwife as someone in possession of special knowledge and skills does not endow her with a superior position in the relationship. Indeed, most of the informants emphatically stated that such parameters as responsibility, credit, control and power were either equally balanced between the partners in the relationship, or weighted in favour of the client.

> We don't have power ourselves, but we do have power that's there, that's shared, all of us. And I think that's where the real power is. (Lynn, lines 1218-1221)

> I really don't want to have any control over these women. I want to have power with them, but I don't want to have any power over them any longer. (Ruth, lines 981-984)

Jean supplied a contrast between the midwifery and medical models when she observed that

> It's like he's gotta take over. Like, either he doesn't like what you're doing, or, or he only knows it one way, or he wants credit for the birth. And, and I don't, I don't want credit. I just want her to have a nice experience, you know. But, um, but it's like, he's gotta take over, so that he gets praise after. And a lot of people

> do the, "Oh, thank-you doctor."...But it's too bad that some ego comes into there, and it shouldn't. (Lines 1103-1115)

Two closely related factors are credit and responsibility. The informants were very clear that the major responsibility for the birth lies with the woman, and that the natural outcome of that responsibility was that she received credit for her achievement, the birth:

> But it's not up to me. It's not me that makes or breaks it. Not at all. It's the woman. (Irene, lines 794-795)

> Really it's the mother that gives birth. And the midwife can assist, but the midwife doesn't do it for her. That's really her responsibility, the mother. (Patricia, lines 49-52)

Acknowledging the mother's essential responsibility for the birth in no way minimized the midwives' responsibility for the performance of those professional functions which she brings to the child-bearing process, by virtue of her knowledge and skill. What it does acknowledge and reflect is the midwives' belief that birth is more than a professional event. That part for which she is responsible is very small. Irene explained the difference between an interaction that attributed primacy to the midwife and one that acknowledged the primacy of the birthing woman and family, an approach which she valued:

> And afterwards say, "Oh midwife, I'm so glad you came. I couldn't have done it without you." And those kind of things, I don't even want to hear. 'Cause she could have. You know, it's--you're part of it but so many things are part of it. Her family, her partner, you know. Anything, and the midwife is just a little tiny puzzle piece in the whole puzzle. And I don't want to be more than that either. (Lines 806-815)

This belief in the multi-faceted, holistic nature of childbirth is reflected in the midwife's belief that the woman's attitude and assumption of responsibility are reflected in the actual birthing process. Therefore, failure by the mother to assume responsibility is seen to lead to difficult labours or complications which compel professional intervention, either on the part of the midwife or through referral to the medical system:

> Some of the clients were people who thought that if they hired a midwife, instead of giving the responsibility to the doctor they gave it to the midwife. And as much as you try to give it back, and they would espouse that, in reality they still wanted you to do it for them...And they would often end up being the marathons, and the kind that would really drain you. Drain more than one of us. (Lynn, lines 410-422)

At times, of course, the balance of responsibility and control could change if untoward developments emerge. At any time, a midwife must be "prepared to deal with a problem, recognize a problem, deal with it appropriately, with equipment and her own skill" (Patricia, lines 24-27). At these times, the pre-existing relationship became even more important:

> ...and I guess that's why it's really important for me to have developed a really strong rapport so that if I actually do need to say, "Do this. Now!" they trust me enough that they will. And um, the few situations that we've needed to, it's just like we've worked together, you know, everybody, the midwives, [the woman, and the family]. (Lynn, lines 1253-1260)

It seems clear that in times of emergency a sense of mutuality persists-- there is an underlying bedrock which even an unexpected event cannot eliminate.

Freedom of choice can be regarded as a measure of the balance of power. Jean, while discussing the difference between home and hospital, identified "reasonableness" as the only qualifier of complete freedom of choice at home, but observes that in her experience this is really only a theoretical limitation:

> I think the reason a lot of people--most people choose midwifery is they want control over their birth, and when you go to the hospital you're in a foreign environment, you don't have control of who walks into the room, and you have control over certain things, maybe, but that always changes. And, at home I always respect the family's choice, no matter what. No matter, you know, within reason, I guess, but, never had to make any dramatic changes (laughs). But, you know, however they want to have the baby, whoever they want to be there, what kind of environment they want, that's their choice. (Lines 956-971)

These words intimate a mutuality and rapport in the relationship which goes beyond simple negotiation for balanced power and control, and envisions the second constituent of a lateral relationship, that which concerns the quality of the coming together between midwife and client. The informants felt that in order to ensure the development of a laterally constructed relationship, attributes like respect, honesty and mutual nurturing, which acknowledged the unique personhood of both women, were necessary. The honesty and integrity which are required of the midwife were explained by Irene:

> If you think you can hide something, you can't. I mean, if you try to lie, or hide something, that you're worried, they will know anyway. So, I mean, you have to learn how to be honest and open to people, because this is how you have to develop this relationship, as an honest and open one with your client. And I think you can't hide. If you feel rushed, if you don't want to talk any more, if you feel something is going wrong, I mean it's gonna show, you will show it to them. Even if you try not to. Most people pick it up, and it's going to be an uneasy feeling. (Lines 1969-1982)

Leslie extended this honesty to include the honest sharing of self in the relationship:

> And for me, [it] seemed [that] the midwives [were] able to feel comfortable talking about themselves as well. And that real sharing of who they are with the woman. (Lines 1080-1084)

The fundamental need for honesty and trust was seen by the informants as something more than superficial niceness:

> I may not be the one who appears nice at times, because I may be the one who presents the issues prenatally, what we need to deal with...[If] something needs to be said we speak up and we deal with it. We may not be initially liked for it, but in the long run, it'll help. (Lynn, lines 1126-1132)

Mutual respect and trust are seen as closely associated and absolutely essential to the development and maintenance of the lateral relationship:

> So, really, the relationship is such that there's mutual trust, and respect for each person's role, and how you work together. And that's basically it in a nutshell. (Patricia, lines 64-69)

The beneficial effects of this mutuality can be realized by both the midwife and her client. Lynn speaks about her idealized midwifery practice:

> I would do very select clients. Um, people who are very much like me, who I can relate to, heart to heart, who I end up, invariably, though this isn't my intention at all, I come away feeling as nurtured as all that I've given. You know, so it's a real sharing and exchange. And that just is an aside thing, that, you know, a plus, you know, that--receiving. (Lines 450-458)

This mutuality and reciprocity prohibits the rigid maintenance of scientific or empirical objectivity by the midwife. Indeed, subjectivity is acknowledged as being a major and necessary descriptor of the relationship:

> Is midwifery objective? (Laughs) I don't think midwifery is objective. I think that in getting to know all of those personal aspects of a woman, that will affect her birth, you lose that objectivity. You can't be scientific and empirical in this whole thing. You just can't be. (Ruth, lines 305-311)

The lateral relationship is clearly a unique phenomenon among health-care provider relationships, having more in common with friendships than professional-client relationships. However, there are elements that distinguish it from friendship. One is the education of the midwife, which forms the foundation of the relationship, and has been previously described. Another element, and the second aspect of the unique relationship, is the woman-centred focus of the relationship and care.

Woman-centred perspective.

Focus, or perspective, differs from structure in that the former is concerned with the direction of attention within the relationship, whereas the latter is concerned with the arrangement of such compositional elements as power, control, honesty and reciprocity. In the midwife-client relationship, the focus consistently centres on the client. Alana described how this perspective was actualized in her way of being at a birth:

> I tend to sort of try to be really low profile. Like I find when we arrive at a birth, at someone's home, that a lot of times, it's, you know, we just kind of sneak in almost, and just kind of put our stuff down, and kind of put it out, and if mom and dad are doing really well on their own, just kind of leave them alone until they're

> ready to have us be there, and try to, to really be sensitive to, you know [if] they want everybody out of this room, that that's their space, that's great, if they want us there, to be really actively involved, that's fine too. (Lines 1332-1344)

This woman-centred perspective is one which, once again, acknowledges the entire person-hood of the woman. Therefore the focus is not on her uterus, hormones and pregnancy, but on her as a whole person. Leslie contrasted her perspective in hospital as a nurse to her perspective as a midwife:

> ...when I worked in [the hospital] I did see some of those women...week after week, or sometimes even two or three times in one week. It was still different because...[the reason] they were coming to see me had more to do with a lot of anxiety about a pregnancy gone wrong, and it was still very medical. As opposed to being able to focus on women's experiences, what it is like to be pregnant, what are your concerns at this point, what are your experiences at this point, what are things you're thinking about in the future....[In hospital] we did check those things, but it wasn't the part that was valued. The part that was valued was the prescriptive part. (Lines 827-852)

In a similar vein, Irene criticized the depersonalization that is inherent in the hospital system, thereby illustrating her commitment to an individualized perspective:

> And that's the thing, in the hospital, you strip off their clothes, and put the gown onto them. You depersonify them. I mean, that's the first mistake you do in hospitals. They take their identity away. Why would we? Right there you strip them off! Of one of their powers. Something that they identify with. (Lines 2072-2078)

Indeed, some informants identified the woman-centred focus as the central motivating factor for their participation in midwifery:

> Well, I think my motivation always with midwifery [has] been woman-centred. And so I don't think that has changed. That was the appeal, was working with women, and women making their own choices. (Frances, lines 138-142)

However, there is a mutuality extant within the relationship as well. For example, sharing of self on the part of the midwife takes place, but the defining characteristic of this sharing is that it's purpose is not to be of benefit to the midwife (even though it may be so, as Lynn indicated above), but that it is to be of service to her client.

The relationship has been described as being intentionally entered into, laterally constructed and woman-focused. These elements are actively built and maintained through the commitment of time on the part of both the midwife and client.

Spending time.

The final component of the midwifery-client relationship is the active principle of spending time. Although other strategies are also utilized to build the relationship, the one common thread which joins them together is time. Indeed, the informants recognized the centrality of spending time as the active factor which distinguished their relationship from those of other health professionals. When asked how her relationship with the people she attended as a nursing student compared with her relationship with the clients she attended as a midwife, Ruth responded:

> That was different. We never got the time. We never spent the time with people in nursing schools, as we spend with clients. I mean, from the very first, I have a hard time keeping my initial visits with people under two hours long...[And] that two hour period is probably longer than I ever spent with any of my clients, or any of my patients in hospital. Um, there just wasn't the time to be spent. There's too much to do. Too much busy work in nursing. (Lines 358-371)

This sentiment was repeated time and time again, when the informants compared their relationships to that of physicians, nurses, and nursing students with their clients.

The willingness of the client to commit time to the interaction was also evident in the informants' descriptions:

> The other thing I found really different was the time. There wasn't any rushing. You know, even though there might be women waiting, there wasn't this feeling of rush, and there wasn't this feeling of impatience at waiting either. It was more of, well, I would want the time too. And so, if somebody did take that extra ten, fifteen minutes, then that's okay. It was always so really

relaxed. (Leslie, lines 1054-1064)

Other strategies that were combined with "spending time" included making home visits, being gentle, sensitive and receptive, actively facilitating family/partner involvement, actively constructing the practice environment to promote self-care, and wearing regular, casual clothing.

In describing their relationships and their strategies for building them, the informants also shared what they felt were the consequences, or outcomes of those activities. These parameters will be described next.

Outcomes of the Midwife-Client Relationship

While outcomes may appear to constitute the **reasons** for the activities heretofore described, this is only partly true for this group of women. The informants disclosed an intentionality in the relationship which stemmed from their pre-existing loyalty to a specific relational model--the one they were describing. Outcomes, therefore, were both serendipitous beneficial results and the intended goals of the activities which fashioned the unique relationship.

Two groups of outcomes emerged. The first concerned the nature of the midwife/client relationship itself, and the second involved outcomes not directly part of that specific interaction. Although by necessity these outcomes will be separately described, they are clearly very much enmeshed with both the dynamics of the relationship and with one another. Indeed, to refer to them as outcomes **only** is somewhat misleading, because many are also an integral part of the intention and dynamics of the relationship. These interactional connections will be further explored in the description of the relational model which will follow this description of outcomes.

Relational outcomes.

1. **Each relationship and person is valued.** In direct consequence to the laterality, mutuality and time spent on each relationship, it becomes important and valued of itself, as does the person who is the partner in that relationship.

Leslie observed this valuing in terms of the enjoyment of the relationship. Whereas women found the physician visits a "nuisance", in the midwifery clinic, the "women seemed to be looking forward to their visits" (lines 1001-2). Irene, in reflecting on how she would decide to accept clients if her practice became too busy, noted that there would always be room for former clients, because of the value placed on the relationship that had been built up.

2. **The relationships are strong and personal.** Frances stated that:

> With some people [the relationship's] a lot stronger than with others, but I wouldn't say there was anybody that the midwife cares for that she doesn't develop a close bond with, otherwise it wouldn't work. (Lines 210-214)

This quote clearly demonstrates the strength of the bond that grows out of the lateral construction and time spent on the relationship. It is also clear from Frances' words that this outcome reinforms the ongoing development of the relationship--"otherwise it [midwifery practice] wouldn't work." In other words, the bond that grows makes possible further strengthening of the lateral relationship and greater time commitment.

Other descriptors of the bond included trust and knowing:

> There's something that you build up over time...I guess it's a trust, and a knowing. (Irene, lines 1895-1905)

> In order to build trust, there has to be something other than just a professional kind of relationship. (Leslie, lines 74-77)

Jean described the close bond which develops as falling in love, and related that back to the open nature of a woman in the child-bearing period and the special knowledge of the midwife:

> You bond much more. You know, women often fall in love with their midwife, and sometimes the midwife feels the same about them, and you, you know they--like sometimes people have said, "Oh, you know, she's just like an angel. You know, like she just knew exactly what to say and what to do." And, I think, when you're in a vulnerable position like that, you, you can think that more often, but it's part of that knowing what to say and what to do at the time [that] just comes from experience and knowing what's coming next. (Lines 977-990)

3. **Each relationship is unique.** Because the midwife and the client each enter the relationship as individual persons, as well as occupants of a role, the dynamic in each relationship is unique and can meet the unique needs and desires for those particular persons in that particular circumstance. As Emma observed,

> When I'm working on a one to one basis with different people, it's more...where they're at. Some people will come in and they really need to build something. And, other women [don't]. They're really clear about what they want. (Lines 166-173)

When speaking about the depth of the relationship between the midwife and her client, Ruth also pointed out that each is different:

> I'm not an intimate friend with each of my clients, but I am a good friend of them. Sometimes the friendship lasts for years and years and years. Other times you're a friend for the length of the birth and the post-partum time and then you lose touch. (Lines 292-298)

This uniqueness is also related, as noted earlier, to the individuality of the midwife. Ruth went on to say:

> I think I probably have a different kind of relationship with my clients than some of the other midwives do, and I think that's just because we're all different kinds of people. (Lines 346-352)

The unique nature of the relationship is directly related to both the woman-centred perspective, which keeps a **particular** woman clearly in focus as the purpose for these activities, and to its lateral construction, which allows and encourages the meeting of midwife and client in full personhood.

Extra-relational outcomes.

1. **Long term friendship and connections.** Many informants had experienced the transformation of short-term relationships into long-term friendships, as Jean experienced:

> Like even me, with the person who was at my birth, she hardly knew more than I did, if she did, but I still felt really bonded to her, and she's still a friend. A continuing friend seventeen years later. (Lines 1024-1029)

These friendships often changed in character after the official period of professional-client had concluded. Jean expressed her concern regarding the dilemma of continuing a relationship, and finding a way to do that, when continuing it unchanged would drain the midwife unnecessarily. She suggested a way that the dynamics could be altered:

> Some women don't want to let go of that after they have the baby, and keep demanding your time, you know. But, I heard an interesting way to handle that from [another] midwife, who said, "Now's the time for the mother, who's just had the baby to give to the midwife, instead of the midwife giving to her." So, interesting, that they could continue that bond, they don't have to break it. (Lines 992-1002)

Emma noted the continuing educational connection that persists over time:

> I mean, it goes on--it's a lifeline, you know. These people--we, we walk to the park, [another midwife] and I, and people stop and ask us, chat and ask us questions about their kids. I mean, they're, it doesn't matter how old they are. You know, it's still this ongoing sort of educational kind of connection with a--a person that they really believe is, is a part of their life, just as much as we were, they're a part of ours, when we're working with them. (Lines 33-44)

The possible continuation and/or evolution of the relationship was seen as part of a natural flow. Irene told the story of how one such relationship eventually ended:

> I went there once, I took my family there, and went for breakfast with them. And that was fine, cause she wanted us to come and nothing happened after. So it kind of petered out by itself, but I found I wanted to do that, 'cause I think it was important for her too. And I think if they're meant to be, it will happen. But I think many times they start out, but they fade. So I think this is normal. I mean--I really liked her, and I did home visits straight through her pregnancy all the time, so we had kind of special visits. But after that visit, it just--it just didn't happen. Like it was just a natural end. But we had to take it as far as our family meetings....I think they end by themselves, cause they're not, most of the time they're not friendships, they're--there might be times when that happens, but I think most of your clients, it's a letting go situation. It's just a matter of time. (Lines 1836-1862)

It seems clear that, like the initial relationship, the termination and/or persistence of these associations are all unique.

2. **Avoidance of dependency.** Another highly valued outcome was the prevention and avoidance of dependency by the clients on the midwife. Without exception, the informants saw this outcome as directly related to an optimal midwife-client relationship, and as an important prerequisite for other outcomes, such as normal birth and increased self-confidence. Ruth and Lynn, respectively, reflected on the prevention of dependency:

> I don't want them to be dependant on me. I don't want them to say, at the end of their birth, "I couldn't have done it without you." I think, whenever I hear that, I just go, "Rats, I missed! I did something not quite right." I want those women to say, "Look what I did!" (Lines 984-990)

> For me, I always feel that I've done my job really well as a midwife if the couple come through it thinking that they really did it on their own. And, um, so often you see couples who are so praising the midwives and the doctors and the nurses, you know, "I couldn't have done it without you." That's not empowering the people. (Line 1113-1120)

This absence of dependency was not seen to minimize closeness. Closeness and independence were seen to be able to coexist within the relationship:

> I think, I think there's a really fine balance between having a really good, good relationship with a woman, but still keeping [it] as an independent relationship. You know, we become close, and we have trust, but without dependency. (Irene, lines 796-801)

This outcome is clearly seen as a **reason** for and explicit objective of the midwife/client relationship, a conclusion that is further supported by the fact that, as mentioned previously, two further outcomes were at least in part mediated by this avoidance of dependency. They will be described next.

3. **A normal, positive birth.** Many informants saw the relationship as directly related to the promotion of a normal, healthy birth. As noted earlier (Irene, lines 2169-2189, p.37), it was strongly held that if one attends to the woman's needs for affiliation, encouragement, and various other emotional, spiritual or social needs, she will attend to her own physical health and the

health of her child. Although this strategy was not seen as an absolute reassurance, it was an essential component. Intimate, detailed familiarity with the client, developed through the relationship, was seen as the foundation upon which the midwife could base her professional work. Lynn explains:

> I would much rather work with things really a lot prenatally, because I really believe in doing a lot of prenatal stuff. Like, starting as early as the couple wants--in fact, I don't accept a couple if they [say], "Well, we'll come and see you at term, or close to it." No. I want to know you guys really well. I want to know your strengths, you weaknesses, you know, all this stuff. Um, and for me, to know that and to be able to have a really good working relationship with that, I can understand how this couple works, you know, so I can facilitate their own processing, and safeguard that it's gonna stay within the normal range. (Lines 1161-1176)

Patricia explains how this outcome is mediated by the prevention of dependence on the midwife:

> You really want to encourage and facilitate that relationship. Not be offering yourself as some kind of saint, or saviour, or a rescuer, 'cause then, usually, you have to become that. That's my experience, anyways. That if people come to you looking for the birth on the silver platter, then usually there's going to be something that will happen during the course of that pregnancy or delivery that will in fact necessitate some kind of intervention. And a change of role. (Lines 52-64)

4. **Growth of confidence in the client**. The final outcome which the midwives described was an observed growth of self-confidence within the birthing woman. This outcome has been alluded to in many of the previous quotes, indicating its close association with relational descriptors and its partial mediation by the prevention of dependence. Irene made a connection between laterality, responsibility, support and self-confidence:

> I'm not here to tell you what to do. I'm here to give you support. In your [birthing] process. You know, so you can feel good about yourself. (Lines 1700-1704)

These outcomes complete the description of the special relationship between midwife and client. A number of interactions and connections have been alluded to, and in the interpretation and explication of those, a graphic model of this relationship can be drafted.

Model of the Midwife-Client Relationship

A graphic depiction on the model which emerged from the data analysis is shown in Figure 1 (see page 57). Midwife and client enter the relationship independently, and with intention and commitment. From this conscious beginning comes the **substance** of the interaction. Lateral construction and woman-centred perspective both have a mutually enhancing association with the third element, time.

The various outcomes are all uniquely enmeshed with the constituent elements of the relationship, in that the relationship generates outcomes, these outcomes foster the deepening of that relationship, and so on. For example, woman-centred care results in a unique relationship, which further contributes to individualized, woman-centred care. In like manner, the amount of time spent with the women, and the maintenance of a lateral structure promoted the development of valued, intense personal relationships. Outcomes also interact with one another in this circular manner: as the relationship becomes more strong and personal, it becomes more valued and unique, and vice versa. Therefore, it is clear that outcomes also participate in the substance of the interaction, and to be completely true to the described model would require a multi-dimensional depiction. The circular and criss-crossing arrows connecting the many elements and outcomes with one another portray an attempt to more honestly convey this structure.

These connections, as illustrated in the beginning model, confirm the significance of this unique relationship to the midwives' practice. Ruth clearly demonstrated the importance of these interactions when she reflected on the basis for the radical difference in the attitude towards women and the celebration of birth in a midwifery practice, as compared to a nursing/medical environment:

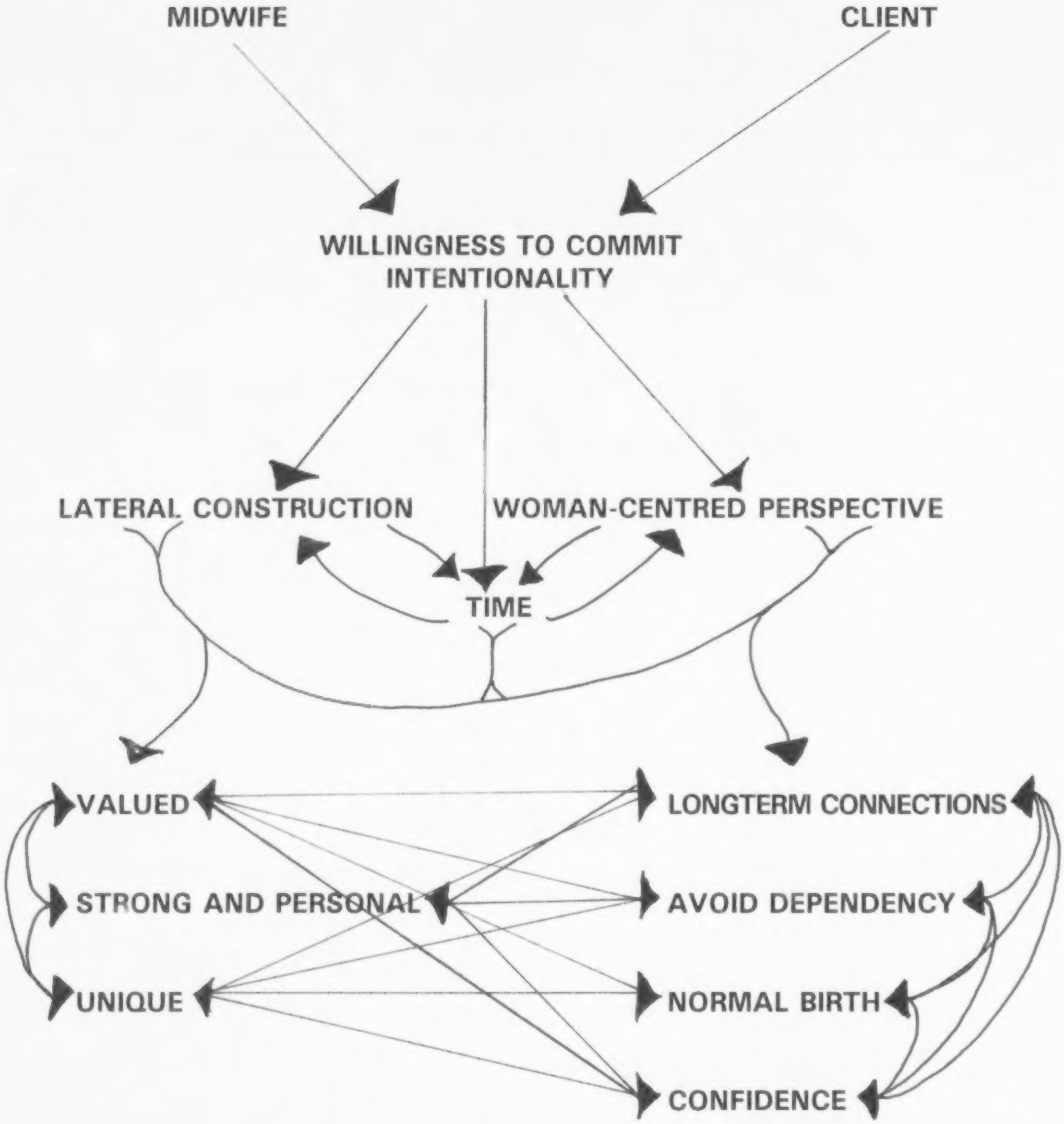
MIDWIFE
CLIENT
WILLINGNESS TO COMMIT
INTENTIONALITY
LATERAL CONSTRUCTION
WOMAN-CENTRED PERSPECTIVE
TIME
VALUED
STRONG AND PERSONAL
UNIQUE
LONGTERM CONNECTIONS
AVOID DEPENDENCY
NORMAL BIRTH
CONFIDENCE

Figure 1. Graphic Depiction of the Midwife/Client Relationship.

> I think that's part of the fact that our clients become our friends. And, I don't think it would be as important to me, if I didn't know the person at all. I think that nurses that are working on obstetric floors are really disadvantaged.... 'Cause there's these people that are coming, and they don't know them from a hole in the wall. Well, I mean it's, you spend fifty hours with somebody over the course of a pregnancy and birth, you know about them. And they are special. (Lines 926-937)

Conclusion

The discovery of a consistent definition of midwifery, including a cohesive model of the unique relationship which develops between midwife and client, supports the exploration for consistencies in the process by which these women became or were becoming midwives. These consistencies proved to be present. Indeed, as will become clear, the parameters which define the role of midwife were found to be inextricably enmeshed with the elements that constitute the process of becoming one. This process will now be described.

The Process of Becoming a Midwife

The process of becoming a midwife was found to take place in four distinct steps: a preparatory period, the decision, an intentional period, and achievement. Each of these is composed of several themes, many of which overlap, but in each step, their is a slightly different expression of these themes. A core category, learning according to a relational ethic, was found, and will be described in the last section of this chapter, wherein the model of the process is described. The component parts of the process will be described next.

Preparatory Period

As with any life event, the events which led up to the decision to become a midwife could be said to begin at any arbitrary time--even generations earlier, as some women related. The informants were asked, or they spontaneously shared, anything in their personal or family history which they believed contributed to their decision to become a midwife or nurtured an environment conducive to their decision. Most often, as they told their story, they would relate back to events or persons in their past that impacted on the process. For example, Patricia spoke about a history of strong women in her family, and told this story:

> My grandmother, for instance, was born prematurely, at home in England. With a midwife. And the midwife saved her life. So my grandmother was always really supportive of me. You know, she was really early. And the doctor came, I guess the midwife called. and said, "Oh, well,you know, she's not gonna live. She won't live through the night." And, uh, the midwife made her an incubator in the stove. Oven door, box, and kept her alive. And of course, she lived to be 94. (Lines 1980-1991)

With analysis, it became clear that three distinct activities which originated during this preparatory period eventually became integral to the process. These were a) acquiring knowledge and skills useful in midwifery; b) discovering goodness of fit for midwifery, and c) conceptualizing midwifery. To varying degrees, all three activities persisted following the decision to become a midwife. The actual expression of the activity was not necessarily identical, but was recognizable. This progression will become more clear as the description of the process unfolds.

Two of these activities, conceptualizing midwifery and discovering goodness of fit, were necessary components of the decision. Acquiring knowledge and skills tended to be more peripheral at this point, but more synchronous with its later counterpart. For that reason, it will be described in conjunction with the actual acquisition of knowledge and skills within the intentional period. The remaining two will be described here.

Discovering Goodness of Fit for Midwifery

Discovering goodness of fit refers to the finding, developing or identifying of qualities within oneself that make one suited for midwifery practice. At this point this activity is not a conscious, goal-directed process, and is not directly associated with midwifery. Indeed, the informants generally have not yet fully conceptualized midwifery, if at all. However, they are discovering and learning qualities that they will eventually realize suit them for midwifery practice. Some of these were realizations whose import was recognized at the time of emergence, and are suggestive of a future career, as Patricia relates:

> I think as a child, I had always had an interest in something to do with health care. With helping people. As a child I was always rescuing birds that had fallen from nests, and trying to nurture them, and feed them, and keep them alive, and that kind of thing. So I've always had an interest in something to do with helping. I knew at a very early age that that's kind of what I wanted to do. (Lines 73-83)

Some attributes were more indicative of the individual's way of being in the world, as when Frances asserted, "I was born a feminist, Alice!"

The qualities that the informants identified as signifying goodness of fit can be grouped into five sub-categories. These are a) respect for persons; b) affinity for human affiliation; c) affinity for autonomy; d) acknowledgement of a greater reality, and e) affinity for human birthing. In addition, the conditions under which these qualities were discovered were also identified, and can be grouped into six sub-categories. These are a) the transformative experience of one's own births; b) innate knowledge; c) discovery from and within their family of origin; d) travelling; e) reading, and f) antecedent employment and education. These sub-categories and the conditions under which they occurred will each be described.

Qualities which signified goodness of fit.

1. Respect for persons. An important constituent of goodness of fit was the respect the informants showed to other persons, and the importance they placed on that respect. This sense of respect is evident in the emphasis on honouring the personhood and unique individuality of all others, in the definition of the birthing woman and her family, rather than the professional caregiver, as central to the birthing process, and in the importance placed on acting according to that respect for the other's uniqueness.

This quality of respect is discovered in both its absence and its presence-

-through contrast as well as consonance. Irene told a story that portrayed both the absence and presence of respect in a hospital setting, where she worked as a nurse:

> I remember, especially one old man. He must have had a minor heart attack, and he was living by himself somewhere, and he's was like, he had his woollen socks on, and he had a little toque on. And he refused to take this toque off. He was very quiet, and one of the nurses was, I remember she had long fingernails, painted red. She was kind of brazen, and not very warm. [And she kept trying to get him to take his toque off.] And he said..."You know, I don't like her, 'cause she doesn't really care." ...But he liked me, 'cause I sat and talked to him. (Lines 1657-1673)

Respect for personhood appertains both to respect shown for oneself and for others. In experiencing it themselves, the importance of extending it to others was recognized by the informants. Jean spoke of learning about respect for person from the way she was treated by her mother:

> Maybe part of it was upbringing. I mean, like, you know...knowing when not to give advice and things like that. Like, I always remember, now that I have a child, just things that I, you know, other people complain to me about criticism from their mother, or something, and I go, "Oh, my mother would never do that, she might think that, but she'd never say that." So I never had to deal with that, that kind of thing. But, um, you know, not saying certain things, or, at certain times, or whatever, to hurt people's feelings. You know, that kind of thing. (Lines 1122-1137)

Patricia encountered the absence of respect from her physician during her pregnancy:

> By that time, there was one hospital in [the city] that would allow a father to be present for a delivery. So I switched doctors, got into that hospital, and went to my doctor with a list. Of what I wanted, and went through and explained that I wanted a different delivery position, didn't want an episiotomy, wanted to breast feed, wanted to go home early, have my husband there, et cetera. And he was kind of like, "Oh, sure, sure! Fine, fine. No problem." But each visit subsequent to that first one, I became very distressed, because he couldn't remember my name, [and] he was more interested trying to sell me on a tubal ligation eight hours after the delivery then with my concerns with how this birth would actually be. And I just thought, "Well, you know, I don't

> trust this fellow. You know, he's very patronizing. He's not taking me seriously." And I knew it. (Lines 541-563)

Many of the informants travelled abroad, or were exposed to other cultures prior to their entry into the process of becoming a midwife. Here, they discovered within themselves an appreciation of the diversity which characterizes the human world. Alana explains:

> I lived in [another country] for four months. Actually I toured ... for a year, and four months out of that year we actually lived in [this country] and worked over there. And...it was a good experience, like it's nice to be a minority somewhere and to know what that's like, and learn to respect their culture and their way of doing things, and I think the best advice we ever [got] was just, "Remember, it's not wrong, it's just different." And, uh, I think that's true a lot with the way women birth. You know, there is no wrong way to give birth, it's just different. So, I think that's probably been a good training ground there. (Lines 849-864)

She goes on to explain how this appreciation of diversity is manifested within her social circle, and how this suited her well for the vocation she had chosen to pursue:

> My husband and I have always had a really broad base of friends and acquaintances. The kind of people that you never want to put all in one room, it's too awkward. No. I think because we've always sort of had that, that sort of personality where we're comfortable with a broad range of people, it's been easy to fit into the mold of a traditionally-trained midwife, because I spend a lot of time with people that are really quite different from what I'm like, and what my background has been, and yet feel really comfortable there too. (Lines 830-844)

Another indication of respect for personhood was the attitude the informants found desirable towards infants and children. Patricia tells of her experiences with her own newborn daughter:

> [I remember feeling] really concerned about what the baby had gone through. I mean, you love your baby. And you know that you do. I remember the first time I actually got to hold her...and they finally brought her to me, and I almost felt guilty unwrapping her, and making sure, you know, all those toes and fingers were there, and checking her out. And, I was talking to her, and we were looking at each other, and we both smiled at each other.

> And the nurse came into the room, and I said, "Oh, look, the baby's smiling!" "Oh, no, no, no, no, dear, that's just gas, they can't see a thing." And of course, back in those days, that's how they treated babies, just like a piece of meat. Insensitive, that it didn't matter what you did to these little things, they didn't really feel it anyway, you know, it didn't matter...Well, I knew at that point, I just thought to myself, "Okay, I know she's looking at me, and I know we're smiling at each other. I don't care what you say." (Lines 374-403)

Emma's concern for the personhood of children emerged in a different way, as she explains:

> You know, I've thought about this many times, about how it was that I got turned on to this, because I was somebody who--who didn't even like kids, in the sense that--and I, and I say that with caution, because I love kids. But, I think what was happening for me when I was younger was that I didn't--I really didn't like seeing what was happening to kids. And, so what, how I protected myself from that was to be able to say, "I don't like kids, I'm never going to have kids. I'm never going to have to deal with it." (Lines 288-301)

This valuing of children also pertains to the valuing of the family, and the individuals and relationships which make up the family. Alana asserts:

> My home and children were more important. I always questioned these women who "had to have a baby, just have to have a baby," and then have this baby and hire a nanny and go back to work! (Lines 729-733)

Leslie reveals a predilection for the centrality of the family at births, and thereby discloses her respect for them and their experience:

> And, um, I guess the other thing that was happening at that hospital was that they were--they've always had a family-centred approach. And so we were starting to see kids in births, and we were staring to see um, you know, other family members, and stuff like that. And so things were moving in that direction in a really nice way. (Lines 351-358)

These various examples have illustrated ways in which the informants discovered their affinity for and their desire to entrench respect for persons in both their personal and professional lives. As the process unfolds, it will become clearer how this quality developed and became an integral aspect of their becoming a midwife.

2. **Affinity for human affiliation.** Many of the informants discovered an early affinity for close relationships. For some, this affinity emerged as a nurturing disposition, often early in their lives. Patricia's story on page 60 (line 73-83) illustrates this awareness beautifully, and is typical of several informants. Ruth, in reflecting on why she has never travelled a great deal, attributed her position as nurturer in her family of origin:

> So, I'd always sort of been the one that's been around. I was the caretaker in my family . You know, I was the one who kind of held things together, and maybe that's the other reason I haven't gone very far away. (Lines 548-553)

This nurturing disposition naturally resulted in an affinity for professions which included a strong affiliative and helping component:

> Um, going through high school, I had always thought of either being a vet, or a nurse. (Lynn, lines 44-45)
>
> I thought I wanted to be a social worker. That's what I thought I wanted to be. Trying to help people, you know. (Irene, lines 1529-1531)

The women also spoke about being drawn to close relationships professionally:

> Now, I can look back and I remember connections like that, like even within that first week of nursing education, in obstetrics, having a relationship with this one couple. Just being, you know how you, you connect and the energy's right, and you can just work together, and I remember times like that. I remember times in my midwifery education where that occurred, um, during my midwifery practicum. So I'm not sure when it actually began, but it sort was an evolving process the whole time. (Lynn, lines 477-488)

Leslie conveyed a similar captivation when she expressed envy of an established midwife/client relationship:

> ...there was something in the back of my mind, because I also felt really jealous. I felt jealous that when they came in, those women really wanted them, and they didn't really want me. And, it was funny feeling, like I knew there was something, but I wasn't sure at that point what it was, it was just, there's something back

there. (Line 510-517)

When informed by the quality of respect for persons, an affinity for relationship becomes an affinity for lateral relationships. Lynn explains:

> But I probably have had that kind of relationship just within my life, you know. I do a lot of sports that are non-competitive, like you know, paddling and water sports, and things like that were you are very much in balance. You know, balance with nature, with your own abilities, and skills, and potential crisis situations. (Lines 1281-1288)

A more complete expression of this affinity for affiliation emerged as the process unfolded, in particular the loyalty to lateral relationships, which, as noted, eventually converged with the definition of midwife. This proclivity was clearly evident prior to entry into the process.

3. **Affinity for autonomy**. The third quality which described goodness of fit for midwifery was that of an affinity for autonomy. Once again, this quality surfaced under a variety of conditions and took many forms. Several informants spoke about learning self-reliance very early in their lives, particularly as this related to health care. Patricia explains:

> A lot of those seeds were planted really early in my life. My mother and my grandmother where not the kind of people that have ever had a lot of faith. They've never, ever turned themselves over to the medical profession. My grandmother, for instance, lived to be 94, hadn't seen a doctor in 30 years. My mother's very similar, hadn't seen a doctor in 20 years. Had a blood pressure problem, went to a doctor, found out, yes, in fact, her blood pressure was high. Uh, modified her life style, and I worked with her on that, and got her blood pressure way down, and she hasn't been to a doctor for about 10 years now. They're not into medication, they're not into doctors, they're not into trusting...so I come from a long line of people that don't view medicine as the answer. You know, as sort of like God. (Lines 1959-1980)

Irene had a very similar experience:

> We were very healthy. I can never remember talking about doc-we never went to the doctor...I can't even remember if I ever went to the doctor, did I? Like, they, they were never there. We must have gone to the doctor sometime. But not from the time I

> can remember--I saw the school nurse [for] immunizations, or something like that. We were never sick, and if we were sick, we coped. We never took penicillin. We just kind of lay in bed for a while, and then we got better. (Lines 1493-1510)

The predilection for self-reliance persisted into the informant's adulthood, and informed their perspective if they became pregnant:

> I'm not a strong believer in hospitals or doctors, and have never had to make a lot of use of them, and would [have] enjoyed not having to use them with my first birth. (Alana, lines 106-110)

> I went to a doctor when I was about four months pregnant, 'cause I thought doctors do something special when you're pregnant...I wanted to wait until I was definitely pregnant, you know. And he didn't do anything except want me to get some lab tests, and just say, "Oh, you're okay, dear, don't worry about anything." And I thought, "Well, there's no point in me going back, 'cause I know all that stuff already." You know! So I never went back. (Jean, lines 97-109)

This conviction that they were able to rely on themselves led to several informants' decision to carry out their births at home without professional attendance, since midwifery care was not accessible. These experiences became an integral part of not only their identification of themselves as fit for the role of midwifery, but their conceptualization of midwifery and the acquisition of knowledge and skills for midwifery. Patricia describes the impact of that experience:

> Anyway, we went ahead, and we gave birth and I gave birth at home. To my third child, with absolutely no complication--it was a beautiful birth. I felt like it was really and truly the first time I had given birth. You know, not been delivered per se. And it was a wonderful experience for all of us. Just an incredible experience. (Lines 630-638)

As a reflection of self-reliance, the informants described a strong need to know with their own knowledge, in preference to accepting others' understanding. Leslie's mother described her as having been a feminist since she was four years old, and Leslie explains why:

> I think it's because I've always been a rebel, but not in a traditional kind of kid way of being a rebel, like, I didn't rebel in

> ways like running away from home, or smoking or drinking or any of that kind of stuff, but I always questioned authority. I always wanted to know why I had to do things, and I always questioned things like, social conventions. Like, why do I have wear a dress to church. You know, I don't see why I have to do that.... I wasn't ever willing to roll over and say, okay. I always wanted to know why it was I had to do this, and asking for justifications. And refusing to do stuff. If nobody could give me a good reason. Like if it was just because, that wasn't good enough for me. And so, I guess that's probably part of that and maybe that's a lot to do with why I've ended up [on] the road I've ended. (Lines 1867-1893)

In practice, the informants discovered a determination to apply this inner barometer for knowing with their own knowledge to the quality of their professional work. Patricia shares her perspective on working in a traditional health care setting:

> But I couldn't handle working within that system... [with the] total lack of sensitivity on the part of the managers. And the people in control, and making policies. I have always had conflict with that. And, you know, I dropped out, basically, once I became pregnant. I knew I couldn't go back. I know I could never be part of the system again. Not the way it is. Never. Ever. I, I, I know too much. I'd just be yelling and screaming, I'm sure, all the time. (Lines 1945-1958)

Eventually the affinity for autonomy was realized in the attraction to autonomous, non-normative professions. Ruth explains how she differed from her siblings:

> I've been the black sheep, because I haven't been a high achieving academic. I mean, I've always achieved highly academically, whenever I've done it, but I haven't done the standard thing. Haven't gone and got my Ph.D. yet. (Lines 497-502)

In contrast to Ruth, Leslie related her preference for non-normative professional education to a tendency that began generations earlier among the women in her family:

> I come from a family where on my mom's side, the women are the educated ones, and the men aren't. Although, none of the women worked when they had kids. Like, my grandmother and

> my great-grandmother and my mom, none of them worked when their kids were home. But, all of them have university degrees. And my grandmother in fact wanted to be a doctor, but her parents wouldn't let her. [I] always was really supported in wanting to do things that weren't traditional female things. My family was actually quite disappointed that I wanted to go into nursing. (Lines 1899-1914)

Paradoxically, the affinity for autonomy was not seen to isolate the informants from their clients or society, but rather to enhance their participation in life and relationship. A major support for this merging was the acknowledgement of a reality or force greater than themselves.

4. **Acknowledgement of a spiritual reality.** Many informants spoke about their approach to life and midwifery as being informed by the belief in a greater reality, in which they, and indeed all of life, were immersed. This was manifested by an attraction to the spiritual nature of birth and life, in the predisposition for acceptance of the flow of life, and the imperative to acknowledge one's inability to effect complete control over events. Emma spoke about her upbringing as being integral to this recognition:

> When you take birth and death out of the home, and put it in and institution behind doors, and you exclude family members from that process, and you look at it as though it's an event that could have been changed, could have been different, had other people been in, you know, the professionals been involved, then you're sort of assuming that life is something that is not fluid. It's something that is meant to be here, is meant to be saved, is meant, you know, everybody's meant to live as long as possible, and no baby is ever supposed to die. And I think that we've changed a relatively natural life cycle into something that holds a lot of other expectations to it...Certainly there's instances where we all would be devastated by the death of our own babies, just as much as we would by the babies of our clients. But there are times when that's the way it is...
> Interviewer: Where do you suppose this approach came from?
> Oh, it's around, it's incorporated into our upbringing too...When I was a kid my grandmother died in our home, and it was just understood that we wanted her to--my mom wanted her to be there. And, she understood that, sure, she could go to the hospital, but...I think I had a fairly balanced upbringing in terms of

> recognizing the life-death process. (Lines 823-887)

Emma's words reflect deep commitment to the values inherent in the acknowledgement of a spiritual reality. Other informants spoke of their religion and/or their philosophy of life as informing this attribute.

5. **Affinity for human birthing**. The final quality that was discovered during this antecedent period was a captivation with human birth, and particularly with natural, woman/family-centred/directed birth--what was later to be identified as the work of midwifery. This quality was sometimes dramatically discovered through its absence (in a profound disappointment with the way birth was carried out in the dominant system) and sometimes through its presence. Patricia speaks about her first birth in hospital:

> Baby was sent to the nursery, Dad was in the waiting room, and I'm laying in recovery, thinking, "Well, this is childbirth? My God!" You know, I mean, if I ever have another baby, there's got to be a better way to do this, this is just horrendous! You know, here I am laying there, while I've just had a baby, but where is she? You know, like no reward even, after all of that! And, I, I felt really, totally crushed. And, and, just, almost betrayed, you know, I felt like, "Well, you know, how come I didn't know it was this bad?" You know, it's like, "I'm a smart person, how come nobody told me, or warned me, you know, that this could happen this way." You know, and it seemed like this was normal. This was regular stuff, this happens all the time! So what are you complaining about, you know, you're alive, the baby's alive. Don't complain. You're just lucky. You know, I was also made to feel like I really had a hard time having babies. You know, that it was kinda my fault. (Lines 311-336)

However, there was a dramatic difference following her third birth at home. In telling that story, Patricia conveyed her deep loyalty to this special type of birth, and its roots in her own personal experience:

> I just felt different after I'd had my third child at home. I just felt marvellous, and I felt, well, "Now this is an experience that more women need to have, that more women are **capable** of, if only they knew it. (Lines 1660-1665)

Several other informants discovered this affinity through their own births, some once again by way of negative experiences, and some by way of a positive, empowering experience. Others recognized it through their work and education. Leslie tells of her experience working on an obstetrical unit:

> I sort of got caught up into the excitement of getting to be even more involved in births, early on in my career. And sort of knowing the real high that you get with being there to catch babies. (Lines 342-347)

In contrast, she found herself developing a disinclination for the technological intervention into that process:

> But on the other hand, because of regionalization, we were getting far more and more high-risk women. And, with having more high-risk women, I was finding that we were often applying the work that we did with high-risk women onto the low-risk women. And I was starting to feel a lot of conflict, when I would take over care from another nurse, who treated somebody like they were high risk, and no one had said, "Why do you have the monitor on", or, "Why did she get an epidural right away, why didn't you try her in the bath tub?" and that kind of thing....And so that started to make me really question what we were doing. (Lines 358-396)

Others discovered the attraction through more indirect means such as reading. When asked if she had any early experience with birth, Ruth told of her exposure in a friend's home:

> Not really. Not really. One of the things that I had done is just, because her library was in the bedroom I slept in, I read the books that she had, and at that time, there weren't very many childbirth books available. There was ... Suzanne Arms, Immaculate Deception, and Grantly Dick-Read, and Hazel, Lester Hazel's book. And that was it. And I read them, and said, this is really fascinating stuff. I like this. (Lines 38-48)

Needless to say, this affinity for natural human birthing would be a significant element in the designation of oneself as "fit" for the work of midwifery. However, it is also clear that this affinity for birthing could not be pursued in the environment of the traditional system, given the informants' other values, namely respect, autonomy and immersion in a greater reality. The informants perceived that these cherished principles were violated by that traditional system. Eventually, the informants would find a place where this sense of "fitness" could be realized in practice. That landmark event will be fully described in conjunction with the decision to become a midwife.

The degree to which the informants developed their sense of "fitness" prior to that decision varied widely. Some came to that point following a long period of searching and self-refection, whereas others came to it with only a sense of "I" as suited for this work. This phenomenon will also be more thoroughly explored when the actual decision is described.

Conditions under which goodness of fit was discovered.

In describing the qualities which constituted goodness of fit, reference has already been made to places and conditions under which that occurred. These will now be described in somewhat greater detail.

1. **Transformative experience of one's own births.** As mentioned previously, the informants' own births prior to entry into the process influenced their discovery of goodness of fit in two ways. First, by providing a contrast to what they knew or intuitively felt could be different. As Patricia said, "I knew there had to be a better way." Secondly, by actually having a successful "different" birth, which was in keeping with their vision of what birth could be like. Some informants experienced both, and others had not themselves given birth at this point. A wide variety of qualities were discovered in this experience, including self-reliance (autonomy), respect for persons (particularly families, the birthing woman and the newborn) and an affinity for natural, woman-directed birthing.

2. **Innate knowledge.** Many of the informants felt that some things just came from so deep within themselves that they could not name a source. These discoveries did not seem to emerge from anything external to themselves. Statements alluding to this type of discovery would usually be preceded with "I have just always..." or "I just knew..." and "It was just there. I don't know where it came from." Qualities that were felt to be innate included the affinity for autonomy (especially the need to know with your own knowledge), the affinity for lateral relationship, acknowledgement of a spiritual

reality (especially the affinity for spiritual things and belief in the flow of life), respect for persons, the affinity for human relationship (especially a nurturing disposition), and the belief in and affinity for natural birth.

3. **Discovery from and within the family.** Of course, the informants learned and discovered many of these qualities within their family of origin. The qualities that were mentioned as originating here were usually ones that were modeled, though occasionally informants discovered qualities in contrast to those predominant in the family. For example, Ruth mentioned that while she was a high academic achiever like her family, her expression of that achievement was non-normative, unlike that of the rest of her family.

Qualities that were informed by the family environment included respect for personhood, both generally and of children; a nurturing disposition; knowing with your own knowledge; affinity for non-normative, autonomous professions; self-reliance; acceptance of the flow of life and death, and affinity for natural birth.

4. **Travelling.** Many of the informants had lived or travelled outside Canada, or lived in various regions within Canada. Only two informants had never lived outside Alberta at some time. Those who had felt that this experience was an invaluable catalyst in the development of their respect for diversity and personhood.

5. **Reading.** Several informants mentioned discovering their goodness of fit in response to their immersion in the alternate birthing literature. Several books have already been mentioned (Ruth, p.70). These same books were mentioned again and again, as was Ina May Gaskin's Spiritual Midwifery. Generally, reading contributed to the embedding of two qualities: respect for persons, and belief in natural birth.

6. **Antecedent employment and education.** The final, but certainly one of the most significant conditions under which goodness of fit was discovered was antecedent education and employment. This education and employment was consistently in the health care field, though not necessarily in maternity

care. Indeed, most often it was not. As mentioned in the previous section, the informants responded to both consonance and dissonance in these settings. The sheer volume of qualities mentioned in this area is second only to those attributed to the informants' experience of giving birth. This does not suggest that this was an important condition for finding goodness of fit, but it may suggest that these instances were well remembered, and that they were therefore an important condition for crystallizing their sense of self as "fit". For some, it was pivotal, as Leslie points out:

> Well, I guess for me, coming to decide to be a midwife came later, not as a child. I had absolutely no interest in health professions as a child. Absolutely none. I thought I wanted to be a mathematician. And, um, in university, or not even in university, even before that, in high school, right up to the very last year in high school, when I was just about finished, I was convinced I was gonna go to university and do something in maths and sciences. (Lines 106-119)

However, due to a number of unforeseen circumstances, Leslie found herself in nursing school, which she hated but with one exception:

> And, I guess when I started my obstetrics rotation, was into my second year, I think it was my second to last rotation in specialty areas, and I really liked it. (Lines 153-156)

Eventually, with employment in the area, she came to the realization that

> ...maybe I'm okay at this! Instead of this being something that's not really me, and maybe I'm not really understanding what I should be doing, and that sort of thing. (Lines 300-303)

Qualities that emerged during education and employment were respect for persons, generally and for children, respect for the centrality of the family, affinity for lateral relationships, affinity for autonomy, affinity for human affiliation, affinity for natural birth, and acceptance of a spiritual reality.

The attributes which the informants perceived as rendering themselves fit for midwifery and the conditions under which those attributes appeared have been described. However, on their own, these attributes are no more than a collection of personality traits. In order to signify for midwifery, it was necessary that the informants also have an image of what midwifery meant. The process of conceptualizing midwifery will now be recounted.

Conceptualizing Midwifery

At approximately the same time as the informants were discovering their goodness of fit for midwifery, a parallel process was taking place--that of conceptualizing midwifery. Because there was essentially no recognized midwifery profession in Canada, it was necessary for informants to creatively develop and acquire a concept of what a midwife was before they could say that they were going to become one. This process was essentially separate from their discovery of goodness of fit, up to the point of decision to become a midwife. The significance of this fact will become clear as the description unfolds.

Once again, there was a wide range of complexity and development in terms of the informants' concept of midwifery. For two women, this conceptualization was essentially limited to knowledge of the word "midwife", as Emma explains:

> I'd never been exposed to it before, I didn't even really know what a midwife was. But I, all I knew was that that was what I had to pursue. And it was almost that simple. (Lines 318-322)

Essentially three components described the informants' conceptualization of midwifery. These were a) midwifery promotes a better birth; b) midwifery is possible, and c) midwifery is necessary. The process of conceptualizing took place under a number of conditions, some of which are reminiscent of the conditions under which goodness of fit was discovered. These were a) reading; b) felt need; c) exposure to midwifery practice, and d) through friends and consumer groups. These will be discussed individually.

Components of the conceptualization of midwifery.

1. **Midwifery promotes a better birth.** The informants saw midwifery as a means of providing for others or themselves the kind of birth that they

envisioned as desirable: natural, woman-centred, baby-friendly, empowering, safe, and spiritual.

Irene was searching for a means to protect women from the incompetence she had experienced:

> I always felt like it was a bunch of incompetent idiots that had been dealing with me. They hadn't informed me about my options. And I didn't even know what was happening [at] first. Of course now I would never have allowed what happened to me to happen again. I mean how many women are often in that situation. They don't know. And I somehow, I always felt, if there's somehow--how could I stop this, how could I ever do something for this not to happen to another woman. To be totally driven over and destroyed. (Lines 242-255)

Eventually, she came upon midwifery as the solution to her quandary.

In common with others, Patricia had read that birth could be different and saw a midwife as being the one who could help make this so:

> And by that time, there were a few books that were coming out. You know, the childbirth movement was coming. And so my husband bought the books prior to getting pregnant with his first child, my third child. "The Birth Book" by Raven Lang, and "Immaculate Deception" by Suzanne Arms. And we read those books and I thought, "Well, that explains it." I mean, it totally explained what my experience had been, why, and it also gave me optimism. That it could be different. That birth could be very different. And I started to think about a home birth. And a midwife. And then I got pregnant. And so we searched for a midwife, or a doctor, to help us to give birth at home this time. (Lines 525-541)

Lynn experienced midwifery care as the catalyst for opening the birth to spirituality:

> Midwifery and it probably complemented each other. And just worked together, within, they're very entwined. I mean, the spiritual aspect of midwifery is something that has always been really important. Yet, I couldn't tell you when or where I first became aware that that was there. I know that one birth in the country, 'cause you can, you can feel it so much when you're on your own. (Lines 1373-1382)

Others' conception of midwifery as promoting a better birth was mediated by their own needs and desire for a home birth:

> Um, I first got into midwifery when I was pregnant ... and I did a lot of reading and I read some books that supported home birth and I decided I wanted to have a home birth. (Jean, lines 28-32)

> I think the reason that I got into midwifery was when I was pregnant with my first one, there was no midwifery care available. (Alana, lines 83-86)

Both of these women envisioned the birth they wanted, but could not find professional support for that birth. Both pursued their desired home birth, and were largely successful.

Ruth's realization that midwifery promotes a better birth emerged with her observation of a midwife-attended home birth, at which she was simply overwhelmed with the beauty of birth:

> And when she went into labour, I was there. And she says, well, you're here, you might as well stay and help out. So I sat there with my chin dropped to the floor the whole time...It was wonderful. And I thought, "Why doesn't everybody in the world do this? Why do people go to the hospital to have their babies?" (Lines 21-35)

It is clear from these excerpts that midwifery was inextricably bound with home birth. The fact that only midwives would support that option contributes to the perception that their profession promoted a "better" birth.

2. **Midwifery practice is possible.** The informants also needed to be able to conceive of midwifery practice as being possible. At times the informants conceptualized little more than that fact--as Emma suggested when she described the extent of her knowledge of midwifery immediately prior to her decision to pursue education to become a midwife:

> Somehow I got in contact with [another midwife's] partner....We must have sort of been talking about his life too, like his partner, and what she--because I'm sure he must have said something about, "Well, my partner's going into--becoming a midwife."

Jean had envisioned a birth with a midwife, knew that she wanted to do this with her life, but needed the assurance that it was possible before she could enter the process. She found this assurance in an advertisement about an educational program:

> And then, I guess when my [child] was about seven or eight months, I read something about this midwifery training in [another country] which is just lay midwifery. (Lines 224-227)

It was at that point that Jean found the route by which she could become a midwife.

Most of the informants conceived of midwifery as promoting a better birth before they found a way that it was possible. Leslie had encountered community midwives at the maternity unit were she worked, but unlike the others, she did not at first see them as necessarily promoting a better birth:

> In that block of time where I was doing casual work, I was starting to see more and more and more from the midwives in the community...but our sort of contact was really brief. And often they were the, you know, home births that there were problems with, and they were coming in, and you know, there was all that sort of furore that goes along with that, like, "Oh my God, how could they have let her, ever let her be home." And all that sort of thing. (Lines 493-506)

It is interesting to note that the vision of how midwifery was possible changed in relation to when the informants entered the process. Those entering early, that is during the 1970's, had a much less developed concept than those who started later in 1980's and 1990's--very likely because there was no extant example in the community in the earlier period.

3. **Midwifery is necessary**. Closely related to the concept that midwifery promotes a better birth, and perhaps separated only by degree, is the notion that midwifery is necessary:

> So I started getting all these phone calls. From people all over the place. Wow! You know, you've had your baby at home, how did you do it? Will you help us? And I said, "Well, you know, no, I can't really help you, but what I can do is tell you how we did it. And that's what I did...And you know, after several phone calls like this, I realized there was a need. (Patricia, lines 645-656)

Although initially this realization resulted in the development of support groups, eventually it led to Patricia's decision to become a midwife.

Conditions under which conceptualizing midwifery occurs.

As is clear from the description of the components of conceptualizing midwifery, that activity took place under a number of conditions. These will be described individually.

1. **Reading.** For many people, the main source of information about midwives was the alternative birth literature. Informants were drawn to this literature either through their own experiences, or by accident, as with Ruth. The informants stated that they acquired the notions that midwives promote a better birth and that midwifery practice is possible from this literature.

2. **Felt need.** Several informants' experience of a felt need, either in relation to themselves or to another, led to their conceptualization of midwifery. Irene describes her feelings following the discovery of her personal uterine disfigurement due to a poorly executed cesarean section:

> And, uh, that's when it hit me. Like, I was, well, I'm glad I was here. I think I actually would have gone and snipped something off! I was absolutely furious. I was steaming, I was so angry. I mean there is no words for it, I was absolutely blown off [the] earth. (Lines 193-199)

These feelings quickly led to her commitment to do something to prevent such practices, and her conceptualization of midwifery as the means by which this could be done. Informants conceptualized midwifery as promoting better births, being necessary, and being possible as a result of their felt need.

3. **Exposure to midwifery practice.** Several informants had the opportunity to actually observe midwifery practice, either directly or indirectly. One saw community midwives in hospital, one at home. One informant grew up in a country where midwives were the dominant caregivers at birth, and one found herself giving midwifery care. All these instances have been or will be described elsewhere. The informants suggested that they conceptualized midwifery care as promoting better births and midwifery practice as possible under this condition.

4. **Friends and consumer groups.** Many informants heard about midwifery

through friends and one through a consumer organization. These individuals promoted midwifery as being possible and as being the means to a better birth. Learning about midwives through the consumer organization helped that informant understand their role from a cultural perspective.

At this point in the process the women had a sense of those qualities that make them "fit" for something, and they had a concept of what midwifery was. However, the two had not yet coalesced in such a way that the individual could pursue midwifery education for themselves. That would happen in connection with the commitment to become a midwife, which will now be described.

The Commitment to Become a Midwife

In time, there came together a set of circumstances which resulted in each informant's decision to pursue education for midwifery. Though the circumstances were necessarily unique to each individual, it was possible to capture the essence of these various narratives. As noted earlier, it was necessary for the two activities, discovering goodness of fit and conceptualizing midwifery, to crystalize into the concepts "I" and "midwife" respectively. When these are joined together by "am going to become", the commitment was made. However, there are once again other parameters which were part and parcel of this commitment. They were a) antecedent loss of focus/refocusing; b) the decision, and c) focused activity. Each aspect of this step will be discussed individually.

Antecedent Loss of Focus/Refocusing

Immediately prior to the decision to pursue midwifery, the informants spoke either about experiencing a loss of focus in their lives, or of an intense period of refocusing, particularly with regards to their careers. Emma spoke more generally about her life:

> I would've been working up north for a while, and I came down

> to the city, and I was so confused (laughs), as everybody is at one point or another in their lives. (Lines 303-307)

Irene and Leslie, respectively, reflect on a loss of allegiance more directed to the specific career with which they had been occupied:

> And, uh, 'cause I really wasn't satisfied being a nurse, and I really didn't like working CCU, I was kinda tired of seeing people die anyway. (Lines 265-268)

> And I was just feeling itchy feet, and decided that it was time to leave. And I thought at that point that I didn't like the kind of work that I was doing any more as much, and that I was gonna leave nursing completely. And, so I ran away for a year. And did all kinds of travelling, and all kinds of real deep soul-searching about what it was I wanted to do. (Line 404-412)

For Irene, the loss of allegiance and subsequent openness to refocus was secondary to other factors. For Leslie, on the other hand, the loss of allegiance was more central, and contributed directly to a period of intense refocusing. These quotes show that the loss of focus/refocusing could be present for varying lengths of time--whereas for some it was just a vague feeling of discomfort, for another it precipitated a year's "getting away from it all."

The data disclosed an openness in this period which made it possible for a connection to a deeper sense of self to emerge. In this open place, it was possible for the woman's sense of fitness and her concept of midwifery to converge, come into her awareness, and find conscious expression. When that connection was made, she could make the decision to become a midwife.

The Decision

As mentioned earlier, the commitment to become a midwife crystallized when goodness of fit and the concept of midwifery came together in the minds of these women. The actual making of the decision appeared to concur with the period in time when this pairing became conscious. It is interesting to note that there was a wide range of specificity inherent within the actual decision. For some, the decision rose gradually from their subconscious, while for others it emerged suddenly, with brilliant clarity. Note the difference between Patricia and Frances:

> And, about a year after I'd given birth to my third child at home, one of the women in our group, the alternative birthing group, found a doctor...who was willing to attend a home birth. And so she asked if I would come and help. And I said, "Sure, I'd love to!" So I went to that birth, that was the first birth I went to, and really started apprenticing. I guess you'd call it that, although...it was such an informal circumstance, really,...it wasn't the doctor saying, "Okay, I'm going to train you to be a midwife." (Patricia, lines 698-731)

> One day I just woke up and sort of said, I'm going to go into nursing and be a midwife. Don't ask me why. I didn't want to just do nursing. I specifically wanted to be involved with midwifery, but I don't know why. (Frances, lines 28-33)

This wide variation also applied to the range of advance preparation in which the informants had been involved. Leslie, for example, had explored many aspects of the profession:

> And so, I started talking, every time I saw a midwife come into the hospital, I'd just pounce on her, you know, and say, "When you're finished with your birth, can I talk to you, I wanna know more about what's going on, and how to be a midwife, and things, but, um, I wasn't sure at that point, how I was going to go about doing it. (Leslie, lines 572-580)

Emma, on the other hand, knew very little about midwifery, other than the word. For her, it was indeed only a convergence of the elements "I" and "midwife" through the phrase "am going to become":

> And, I'm telling you, other than, "I see--Oh, oh, I guess that's what I'm supposed to do with my life, and I'd better start working on [it] soon." It was that, like it was almost that simple. All I knew was, was that that was what I had to pursue. And it was almost that simple. Somebody kinda smacked me with a big two-by-four, and sorta--OOOH! Oh, you know, it's like waking up from a dream and realizing that you just had a major message to hear. (Emma, lines 313-327)

Many informants considered that there was an element of a "calling", an imperative inherent in their becoming a midwife. A calling suggests a deep sense of destiny, harmony with one's true inner self, and a strong connection with a greater reality. Such a strong imperative would make it possible for the women to trust in and rely on themselves, both in making the decision to become a midwife, and in persisting with that work, particularly considering the unfriendly socio-political climate in Alberta at the time. Irene observed:

> You have to have passion too....I mean, I couldn't even think, I just knew I had to go, and I had to go fast. I couldn't wait. I don't know why, today. I just had to become a midwife. I couldn't wait for three years, for someone else to finish their apprenticeship, and then [start]. (Lines 986-991)

Ruth was even more explicit, and pointed out the significance of a calling in terms of loyalty to and persistence in her chosen work:

> Interviewer: What makes you a midwife?
> Ruth: I think people are born midwives. I think that just as some people know they have to be priests, there are people who know they have to be midwives.
> Interviewer: Do you think there's an element of a calling in it?
> Ruth: Oh, yeah. I mean, there was, it was, I KNEW! That that's what I had to do. Watching this birth, it's like that's what I'm gonna do. Um, and the only reason I wasn't one sooner, is that I had absolutely no exposure, but I'm sure that if I had been exposed to it earlier, I would have been. Um, anyway, oh, yeah, I think it was a calling. And I think that that's why, that's why we've done it for all these years. And we know we get paid real lousy, and have had to deal with all the stuff with the medical profession, and all that, and why we've been willing to risk our necks every time we go out, and to help women have their babies. We have to. It's just--it's just an integral part. Part of one's being. (Lines 747-770)

Clearly the way one learns and offers service will be informed by such a significant experience. Alana, on the other hand, down played the centrality of a calling for herself. For her, it was important to be able to offer a service to any community in the world in which she might find herself living. However, she acknowledged that there was more to her commitment to midwifery than simple practicality:

> ...[In] making the decision to be a midwife, I probably wouldn't have gone this far with it if I hadn't realized when I was at a birth

> there was still that skill, that, that heart-felt part of it. (Lines 596-601)

Lynn was somewhat unique among the informants in that she did not conceive of midwifery as being possible and didn't actually acknowledge that she was actively becoming a midwife until she found herself practising as one. She reflects on her entry into a post-RN program:

> And, I was just looking through the nursing brochure, to see what else there was. And came across this program. And we ended up coming here, and [my partner] ended up going to university....I never thought that I would use [it], personally. As a midwife. I thought I was taking this for my own personal information. I didn't think a lot about things. I just did things at the time. (Lines 56-70)

Lynn's commitment to midwifery clearly did not coincide with that decision, since the necessary elements of conceiving midwifery as possible and fully realizing that she suited the vocation had not yet occurred. It was when she attended her first birth as the sole professional that these came together, and the process became conscious and committed:

> And it was just the most wonderful thing, like I walked into this really neat old farmhouse, way back in the hills, and you could just feel the energy in the place. And it was just--from that moment onwards, that birth just changed me completely. I mean, I'd always been present at birth, or before that, and really love the interaction between people, and the work of it, or whatever, but that did it for me, as far as doing...what I always had known that I wanted to do, but never had brought it to the surface, you know. (Lines 154-169)

Interestingly, and also uniquely, this was also the point at which she completed the process, and became an independent, practising midwife. This anomaly will be discussed more fully at the appropriate point of the thesis.

Focused Activity

Following their decision to become a midwife, the informants focused their activities towards accessing some kind of training or education for this goal. Jean's story demonstrated a degree of commitment commensurate with the sense of calling that accompanied the decision:

> So when my [child] was just two, I went to [another country]. Didn't have much money in those days, so I went and stayed with my parents for that summer before I went, in September, and worked as a waitress, and my mom babysat, and I saved all my money and all my tips, and got a plane ticket....I'd had an investment with my siblings, and during that year we cashed that in, and that money supported me while I was living there. (Lines 284-294)

The decision to become a midwife led directly and rather quickly to the pursuit of knowledge and skill required for such a vocation. This activity constituted what the informants considered the **substance** of the process of becoming a midwife. Although all focused their work in this direction, not all aspirants were able to do so as clearly and promptly as Jean. Several were required to fulfil commitments already made, or pursue ancillary courses not directly related to midwifery. However, the **focus** for all these activities was to move the learner closer to learning and ultimately to knowledge and skill for midwifery.

While they were actively pursuing knowledge and skill, however, the aspiring midwives continued to pay attention to their goodness of fit for midwifery. The details of this aspect of the process will now be described, followed by the delineation of the acquisition of knowledge and skills.

Actively Becoming a Midwife

Evaluating and Finding Evidence of Goodness of Fit for Midwifery

After their sense of goodness of fit and their concept of midwifery converged at the point of entry, the becoming midwives continued to evaluate and seek evidence of their goodness of fit. This undertaking differed from the discovery of their fitness in that it is now evaluated according to their specific notion of "midwife". As a result their sense of goodness of fit narrowed, and was more closely associated with the parameters that characterize midwifery and birth. Four sub-categories described the category evaluating and finding evidence of goodness of fit. The first consists of six **components** which indicate goodness of fit. These are a) being enamoured with birth; b) finding accord with the midwives'/midwifery approach to birth; c) finding discord with institutionalized birth and education; d) experiencing community with midwives; e) finding synchronicity with midwifery clientele, and f) finding agreement with one's life. The second sub-category is made up of the **conditions** under which goodness of fit is evaluated and confirmed. These are a) one's own births; b) nursing education; c) midwifery education; d) immersion in professional and lay literature, and e) attendance at conferences. The third sub-category outlines the **strategies** which the informants applied to the task of evaluating goodness of fit. These strategies can be broadly categorized as intentional or serendipitous, and specifically categorized as a) being attentive; b) assessing; c) comparing, and d) moving towards a philosophical framework. Finally, several indicators provided the **standards** by which their goodness of fit was assessed, namely a) one's internal barometer; b) other midwives; c) one's clientele; d) one's family and e) the literature. Each of these four sub-categories and their various components will now be described.

Components of goodness of fit.

The components of a category are those elements which make up the substance of that activity or process. In the particular, these elements are what provided the evidence that the person fit the concept "midwife", and provided the impetus to carry on. Each component will be described individually.

1. **Being enamoured with birth.** During the discovery phase, the informants described an affinity for human birthing. In this active phase, this affinity appeared to intensify to the point where it could be described as being enamoured with birth. Ruth described this experience:

> I've been to a lot of births, and every time the miracle gets more and more intense. Because I know all these things about growth and development...and there're so many steps, and they always go right. It's very rare that anything ever goes wrong, and it's just a miracle! And you watch these big heads come out of that little

> hole, and the little hole stays intact, and it's just like, WOW! Are women ever built to do this! Hey! It's really neat! (Lines 908-919)

Alana also conveyed this attitude towards birthing when she explained how and why she continued her apprenticeship in midwifery in the face of medical and institutional disapproval:

> Because this [disapproval] is the exception rather than the norm, and the norm is so beautiful. [When you have] a home birth, it's so special, and I think, I think the women should get the choice. (Lines 1234-1238)

As suggested here, the ideal with which the informants were particularly enamoured was a natural, woman-centred birth, as described earlier in the defining attributes of a midwife. Their captivation, however, was not limited to only that kind of birth. Lynn spoke about her enjoyment of learning in the area, even though at other times she found fault with her program:

> I enjoyed it, the midwifery aspect of it so much....It felt right. There were always things I didn't like about it. You know, it was very medically oriented, and it wasn't home based, and my inclination was always that way. (Lines 73-84)

In the data, it was clear that the more the informants were exposed to birth, the more they became enamoured with it. The meaning attributed to this realization was that it made it possible for them to continue in spite of all that conspired against them, and confirmed that this was indeed their vocation. Patricia makes this very clear:

> A lot of times I would just say to myself, "I really feel like I'm from a different planet." Like, how could something that seems to just be so sensible, and it is just common sense, to me, just be so completely unknown to most people...Like, I wasn't sure, but I knew. And I think it was just the fact that I [had] experienced this. Intimately. On such a deep level. The difference in birth. The experience. (Lines 1618-1633)

2. **Accord with the midwifery approach to birth and education.** Finding accordance with the midwifery approach to birth and education flowed directly from the discovery phase of the process in two ways: first from conceptualizing midwifery, that it promotes a better birth, and secondly, from all the

parameters that they discovered as designating themselves as fit for midwifery. At this point, those parameters were further confirmed, as they found synchronicity with this model. As they undertook learning, the women assessed the various and numerous approaches that they saw, and found themselves aligning with that one demonstrated by the midwifery community. Leslie explained how she felt after her first home birth, at which the newborn required some resuscitation:

> Afterwards, I thought, "God. This should have been a bad experience. But it wasn't, it was a wonderful experience. And, I guess, for me it really confirmed that I didn't need all those neonatologists around. I know I can do this. And I didn't need to have an obstetrician, I didn't need to have fancy equipment...and all that kind of stuff. Everything was there that I needed and it worked. And even though it was scary for the family, too, it was, they were there. They weren't separated from that experience, that it was all part of them, and in the end it was such a joyous experience. For everyone. And so I guess that really made me hooked. (Lines 1223-1240)

Irene spoke about feeling positive about how her midwifery program in another country was a reflection of the status of midwives in that country, and how that was consistent with her view of midwifery:

> They have a really good attitude about birth. The midwives are very strong, because they've been doing that for a long time...The scope of midwives there is quite broad, and I like that. You know, that you have kind of a broad view of it. (Lines 485-523)

Alana told of how her inner self harmonized with midwifery practice:

> When I'm actually at a birth, I see some skills and abilities there that are completely independent from that, like, a sort of intuitiveness that has served me really well. Just sort of, what are the people at the birth sort of doing, and where are they at, and where do they need help, and how can I best help out to get them the most involved where they need to be. (Lines 587-596)

Constantly evaluating and finding evidence of their accord with a midwifery model of care strengthened the allegiance and commitment to that kind of care. As Leslie said, "So I guess that really made me hooked."

3. Discord with institutionalized birth and education. The informants relayed a sense that part of their realization that they fit the midwifery model became known through their experience of lack of fitness, or discord, with the dominant, institutionalized systems of birth and education. Leslie spoke about her experience in an institutionalized midwifery program, the sentiments of which are closely reminiscent of Lynn's comments earlier:

> And I got there and she handed me the course outline for what I had to do in that[course] and I started reading it, and I started to cry. And I said, "I can't do this. This isn't right. This isn't midwifery, and it's too much. If you expect me to do all of these births and do labour support, and do all of these other things, I can't do it." And I know part of it was that I was exhausted but part of it was also that feeling of, nobody understands what it is to be really a midwife. What they understand is needing to get these technical skills, but what they understand is coming from a nursing perspective....But part of me in the back of my mind kept saying that, it's because they don't understand midwifery. That it's because they're only seeing the technical part of it. And although we need this course to learn that technical part, somewhere we gotta learn this other part too. (Lines 1302-1330)

When asked if her emphasis on patience as an important attribute of midwives was modeled for her by the midwives in her program, Irene replied:

> No. No, they were patient, but they weren't as patient as I wish they could have been. And I blame it on technology being there, I mean, it's just the same here, you know--technology makes you rush, 'cause it's there. So I think that's a danger. Technology is fast and efficient. And that's what they made birth to be too, and birth is not fast and efficient. So I think that's what technology has done. (Lines 2212-2221)

This statement also disclosed a sense of unease with the ethos of modern, technological care at birth. Ruth portrayed a similar feeling towards the treatment of babies in institutionalized care:

> The women who are there do have some choices. They do have some say in the matter. The babies that are being born have no say. And, they get thrown around, and treated as though they're slabs of meat. Instead of the aware little wonderful being, that's just full, full of life and hope and promise and love. And should be treated with the utmost respect...[You] get taken away from the person that gave you life for the previous nine months, put in a

> plastic box, left to cry, being poked, prodded... (Lines 815-843)

It is clear that these experiences were as pivotal to the becoming midwives as was their sense of accord with the midwifery model in forming their allegiance and loyalty to the latter.

4. Experiencing community with midwives. Closely related to their accord with the midwifery model of care was the experience of finding community with other midwives and birth activists. Several informants considered this experience to be nice, but not essential. Others found it to be an integral part of their development, resembling the support inherent in radical group development and cohesion. Patricia illustrated:

> I went to the first childbirth conference--I felt really incredible! Because I really felt here, prior to that time, that I was, you know, the lone fish in the bowl, in a sense, just like I was from a different planet! You know, I mean, people really couldn't understand me, and just thought, you know, I was just so radical ...And so when I found out about this group and went to that conference, WOW! (Lines 755-767)

Conferences of this nature were mentioned again and again, and likely had significance because of the small numbers they actually practised in Alberta, particularly for the earlier midwives. For those who started their process more recently, the practising midwives provided more of this community. Leslie described her experience of fitting in more with the community midwives than with the institutionalized programs she was part of, even though initially the feeling was not reciprocated:

> I think for me that was the biggest turning point. Because, that's where I was able to really address the hard issues that I was trying to address as a student, and I wasn't getting a chance to. You know, things about choices, the whole issue of home birth, we hadn't even talked about [that] in class. And, I guess I started off with feeling very much an outsider. You know, here I am, this academic person, who is not really seen as being really serious. You know, like I think they probably had had experiences with students before, who, you know, would come in and they'd leave, and that sort of thing and so, I think probably they were surprised that I kept coming back. You know, every week I would be back

> again, with a big smile on my face! You know, what are we doing this week? (Lines 963-985)

Leslie's relationship with the community midwives developed over time to the point where she was an integral part of the group, and the group became an integral part of her becoming.

5. **Finding synchronicity with midwifery clientele.** Another highly significant group with whom the informants sought and found synchronicity was the midwifery clientele. Indeed, many informants regarded this synchronicity as pivotal, particularly since the woman was the central reason for the relationship and their work. Leslie spoke about how refreshing it was to experience a positive response from the women in the midwifery practice:

> I guess the real difference from my experience the year before was that these women really seemed to be looking forward to being there. And not, this is a nuisance that I must do this, and so I'm gonna come, and the doctor can feel my baby, and I'll leave, and maybe it's nice to talk to the student, but there was sort of this feeling of, I have to do this. But not so much, I really wanna be here, and--whereas these women always seemed to be really looking forward to their visits. (Lines 990-1002)

Alana also spoke about how important this synchronicity was to her becoming a midwife, but related it more directly to her motivation for continuing her learning:

> I think I see a real difference in the families that try home births, just in their sort of their values, and the importance they place on their children. Their children are usually a priority. They're not, kind of an addendum to their first life-style. And I think that's--that's significant. That's probably what keeps me motivated in this a lot. Um, is the priority those people place on their kids. (Lines 787-796)

6. **Finding agreement with one's life.** The final area in which goodness of fit was sought and found by the becoming midwives was with their own life. It was well recognized that midwifery was a stress-producing vocation in societies where it was well-accepted and even more so in a culture where it was disdained. Irene explained how she needed to have her life settled before

she could emerge from the process as an independent midwife:

> When I came back, I knew I wasn't--I knew I didn't want to start....And I was still pregnant. And I said, no, I'm not ready. I have to have this baby first. And we were also asked to go to [another] town to work, my husband was asked...So we came, and were just sitting here, dingling, dangling, in the air, not knowing where we were supposed to be. And uncertainty made me feel that I couldn't make the decision to start even. So I realized that you really have to be settled, at least to do this kind of midwifery. When you have to dash away in the middle of the night, you have to be settled, you have to know where you are, where you have your kids, where they can go, where your husband is, where your support is. Or you can't do it. So, I mean, I didn't do anything then. (Lines 545-565)

The need for balance and agreement between midwifery practice/education and family responsibilities weighed heavily on the informants' minds, and they tended to choose modes of education that enabled them to fulfil their obligations in both spheres. Frances described her feeling about practice as a midwife, a sentiment that was reflected by many informants when speaking about both their education and practice:

> Frances: Any midwife can tell you the biggest drain on their life is trying to balance family and midwifery, and remembering to look after yourself. Because you go too far in looking after everyone else.
> Interviewer: Do you think having children yourself was an important part of being a midwife, or...?
> Frances: No. I felt I was a better midwife before I had children. Because my whole life was midwifery. If somebody phoned me in the middle of the night and their baby was driving them crazy, and they couldn't get to sleep, I would go over and hold that baby for two hours. I'd never do that now. Ever. (Lines 450-464)

Alana spoke about how her future hopes could be realized through her midwifery training, as reported previously. The potential fulfilment of these aspirations also impacted on the sense of fitness with one's life.

These elements together make up the activity or phenomenon, evaluating and finding evidence of goodness of fit. They were evaluated and confirmed in the context of a small number of conditions. These will be explored now.

Conditions under which goodness of fit was evaluated and confirmed. As mentioned, these conditions were the context within which the evaluation took place, and related to and followed from those under which discovering goodness of fit and conceptualizing midwifery occurred, but with a narrower scope. This was particularly the case because now there was a more direct process taking place--evaluating according to a conceptualization of midwifery, in contrast to discovering and gradually bringing into focus their sense of fitness.

1. **One's own births.** Several informants felt that the experience of giving birth was crucial to their sense of fitness for midwifery. As Ruth spoke, she portrayed how her own birth contributed to her becoming enamoured with birth and the midwifery approach:

> Anyway, it was just an absolutely incredible experience, and I felt just so strong. I loved it. I loved being pregnant, I loved giving birth, even though it hurt like crazy. And at the end of it, I wondered how anybody who'd never had a baby could ever understand what it was like. On a number of different levels. I think that the intensity of the pain, of the sensations of contractions...I don't think that if you don't experience it, that you can really understand. I think some people who are really intuitive can get a sense of it, and I know that there are some women who have never had babies who are really good midwives. For me, it gave a whole new meaning to the work that I wanted to do. (Lines 465-485)

A third cesarean, this time planned and under spinal anaesthetic, helped Irene to find a sense of fitness for midwifery with her stage of life:

> But I was awake this time. I had a spinal. And I was absolutely--it was so unreal, because I had seen so many...And I kind of saw myself, you know, I could just see. If I didn't see, I knew exactly what they were doing, I could see the layers, 'cause I've seen it, you know...But just to not loose that time was quite, you know, when you realize that you have lost the chance to give birth vaginally just to be part of it at all, is kind of OOOOOH! It's amazing! And then I tied my tubes. And that's fine, it helped to get that decision. (Lines 573-594)

However, while these informants and others felt that giving birth was a crucial condition for the work of midwifery, still others felt that it was less significant, irrespective of whether they had indeed done so. Frances explains:

> You know, I think the only thing that giving birth did for me was give me more credibility with the women. Not that it changed how I practised, or how I felt about myself as a midwife, it's how they felt about me. And I even had one woman who expressed that, when she was pregnant, and I was teaching prenatal classes, she was feeling like, well how could I possibly tell anyone what it felt like, never having been through it, and at the time I actually was just pregnant with [my first child], and when she discovered that I was pregnant, then she felt totally--different about me. (Lines 464-477)

It is important to note from this quote that although Frances did not consider that her pregnancy rendered her more fit, her clients did. While this may have contributed to her feeling of synchronicity with her clientele, it is largely a sense that emerges from the client, not herself. Therefore, it had minimal if any effect on her own evaluation of goodness of fit.

Other components of goodness of fit that emerged at the informants' births were accord with a midwifery model of care and discord with institutionalized modes of care.

2. **Nursing education**. Many informants intentionally accessed nursing education for the explicit purpose of acquiring skills and knowledge for midwifery. While doing so, they serendipitously discovered their lack of accord with the nursing/institutionalized modes of care and birthing:

> I never got being a nurse. I never could be a real nurse...I thought, in some of my classes, it would have been really interesting to sit down and write down what the difference is between nurses, and their philosophy of nursing is, [compared to] midwives. I've never been able to really articulate it...The initial words in my obstetrics rotation in nursing school was, "Birth is a crisis." That's what the instructor came in and said. And that's what they believed...And, birth isn't a crisis. Maybe that's the difference. I've always believed that birth is a normal, everyday part of life. Otherwise we wouldn't be here. (Ruth, lines 876-899)

> I hated nursing, and I did very poorly with it in nursing school, the obstetrics part, because I couldn't stand--when I took the

> [obstetrics portion], they didn't think I would make it because I couldn't stand what was happening at the hospital. (Frances, lines 153-158)

However, Frances also disclosed that she found a sense of accord with her nursing practice when it was accompanied by the autonomy inherent in a midwifery model of care:

> [I liked] my nursing jobs, too, because I worked in small places, and I worked nights, and I did what I wanted to do....When I was caring for women in labour, when I was nursing, I did it the same way in hospital as I do with women now. It's just now I have a lot more experience, and that to offer too. But, I didn't feel like there was a difference in how I treated women then and now, just how they were treated generally was different. (Lines 184-195)

Other components of goodness of fit which were evaluated in nursing education were being enamoured with birth, and finding agreement with one's stage of life.

3. **Midwifery education.** All components of goodness of fit were evaluated in the informants' midwifery education. Many informants accessed more than one source of education for midwifery, such as for example an institutional program plus an apprenticeship, and actively contrasted these environments. As indicated previously, there tended to be a sense of discord with the more institutionalized approaches, though by no means exclusively, and more accord with community-based, apprenticeship programs. Alana, as mentioned previously, found a great deal of synchronicity with midwifery clients in her apprenticeship training, and actively sought evidence that this was so. At times she found herself wishing that she had the option of not being involved in the care of those with whom she could not achieve this synchronicity. Generally, however, this was not a problem. Many assessed their ability to match midwifery with the stages and priorities of their lives in their midwifery program, particularly in the apprenticeship programs, which tended to most closely match the reality of midwifery practice in Alberta of the time. Self-direction in terms of the degree of involvement was found to be very

important, for example, and contributed to the fitness of the person to the practice. The other components which were evaluated in midwifery education, such as accord with a midwifery model of care, have been well illustrated previously.

4. **Immersion in professional and lay literature.** Since the informants were actively seeking confirmation of their fitness, when literature became available, it was rapidly and thoroughly investigated. Indeed, the becoming midwives' husbands/partners often participated by finding and purchasing this material. Those books most often mentioned were, once again, the classics in the childbirth/women's health movements. Professional nursing, midwifery and medical literature was also accessed, though tended to serve as a resource for knowledge and skill acquisition rather than as a resource for fitness for midwifery. The components most often evaluated according to the literature were accord with the midwifery model, discord with institutional models, experiencing community with midwives and birth activists, and being enamoured with birth.

5. **Attendance at conferences.** The final condition under which goodness of fit was assessed was attendance at conferences. As noted in the description of that component, the most dramatic confirmation of fitness experienced here was community with other midwives and birth activists. Indeed, most people placed attendance at conferences firmly in this sphere of community rather than as a source of knowledge and skill. Frances was asked what she felt the function of attendance at conferences was:

> I don't know that it helps in getting knowledge, but it's nice to get in a group of women who are doing the same thing...I think especially the first time I went off to a conference, and I actually got to meet people like David Stewart, and all those people, it was really exciting for us,...all those things are, I think they're an important part of--I think you could go on forever and not do them, but it, they're just nice to do, and share. (Lines 431-445)

Throughout the discussion of the components of goodness of fit and the conditions in which these components were discovered and evaluated there have appeared indications suggestive of the active participation by the informants in the process. This active participation constitutes the strategies whereby goodness of fit was evaluated, and will be considered next.

Strategies for evaluating and finding evidence of goodness of fit.

The conditions under which goodness of fit was evaluated presented themselves in one of two ways: serendipitously, or intentionally sought by the aspiring midwife. For example, giving birth oneself was not pursued as a means to evaluate one's fitness for midwifery, but it certainly provided a rich environment for this activity for several informants. On the other hand, other experiences or conditions under which fitness could be evaluated were intentionally sought--community midwifery apprenticeship being the most obvious. This intentional seeking out of experiences constitutes the initial active strategy by which the informants engaged in the active assessment of their goodness of fit. Leslie described the point where her seeking found its object:

> Um, and I guess finally, somebody figured out that I was gonna explode! And I was given permission to go and spend a little tiny time with the midwives in the community. And so I took great advantage of that, you know, didn't ever turn my head back. (Lines 955-962)

Whether the initial appearance of the condition occurred serendipitously or intentionally, the strategies the informants applied following their emergence to assess goodness of fit were remarkably consistent. Though these strategies will be described in a linear fashion, this is clearly not consistent with genuine human endeavours. In actuality the strategies were employed simultaneously, linearly, or in any combination of these which was consistent with the unique characteristics of each individual and circumstance.

1. **Being attentive.** The pivotal strategy, which set the foundation for all others, was the act of being attentive. Attentiveness suggests a manner of observation which is receptive and yet focused. The informants portrayed an openness which made available to them an depth of understanding greater than, say, someone who had been taught to observe according to a preset list

of rules. Leslie illustrated:

> For me a lot of it came from actually getting that experience of being with women that--And again it was the chance of developing a relationship with them. Getting to know from them what birth was for them. What their experiences were. Rather than it just being, ah, okay, so this is how the baby came out. And this is where you put your hands, and this is how you set up your equipment. Um, it was something more related to, I think experiential learning. And more related to, um, a learning to value the experience of others. Instead of it being centred more on my experience of being a learner. (Lines 1364-1378)

Ruth gave an example of being attentive during her obstetrics training as a nurse:

> I think, I mean, the first one was really disturbing, but I think the one that had the very most impact was a girl, you know, she was maybe 14 or 15, delivering 10 pound baby. And um, she was screaming. Quite legitimately, as she was pushing this huge baby out, doing just a fantastic job, this little girl, pushing out this huge baby, just doing great. She was screaming. Good for her! And, um, the doctor said to her, um, "Oh, come on, it's not that bad!" And I just went, "No!" And then, the head was born, she reached out to touch the baby, and they said, "DON'T TOUCH THAT BABY!" And they took the baby, and they took it out of her, and they wrapped it up, and wanted me take it out to the nursery. So I kind of said to her, "Do you want to see your baby?" And she said, "Can I?' And I just about cried. I gave her the baby, and then went out to face the music, because I hadn't obeyed orders. And it was, it was a horrible, horrible, horrible thing. (Lines 671-694)

It is clear from this description that Ruth was being attentive to her client in ways that were not prescribed or legitimized within the system in which she was learning. This attention to her client, and particularly to her own responses to it would result in the crystallization of a beginning sense of fitness for the model of care being sought. When the sense of difference emerged, the experiences would become amenable to processing by the next group of strategies.

2. **Assessing.** Once the situation had been experienced through attentiveness, it could be assessed simply on its own merits. In the example

cited above, Ruth simply responded to her experience of being attentive to her patient--she found it to be a "...horrible, horrible, horrible, horrible thing."

3. **Comparing**. There was no suggestion in the above example of comparisons to other models of care. It is difficult to say whether it is truly possible to assessing without reference to different models, and this distinction between assessing and comparing may be artificial only. However, in some cases the practice of comparison was very clear and indeed paramount, suggesting that while assessing and comparing may not be distinct, there may be unequal proportions extant in any given situation. The following example reveals a situation in which comparing seemed more paramount. Frances had been asked whether she thought it important for a woman to have given birth in order to be fit for midwifery:

> No, I don't...I think it's good for everyone to experience birth, I don't think you have t have a normal childbirth to be able to help someone else do it, and believe that it's something to do. I think--June was my choice of midwife, and she's a great midwife. Marlene's a great midwife. Why do you need kids to be a midwife? I think you can do it a lot more easily without kids, there's a lot less stress on you! And you don't have someone making you feel guilty, because you missed this or that... (Lines 480-492)

4. **Moving towards a philosophical framework**. The highest level of processing shared by the informants was the attainment of a philosophical framework for their sense of goodness of fit. In the following example, Irene conveyed finding goodness of fit with the stages and needs of her life by the serendipitous procurement of accommodation on the campus where she intended to pursue midwifery education. She placed this event in the philosophical framework, "If you are meant to do something, the things that you need will be provided.":

> We didn't have a place when we left. But everything was working really well. So, again I think, it was just one of those things that are meant to be. 'Cause I went there and we were number, was it three hundred, two hundred and twenty-six, on the list for student housing. And I went into the office, and said, "Please, I'm

> here, I have two kids, my husband is still in Canada...I need a place to stay." So it was kind of funny, 'cause this guy just came in, five minutes ago, said he didn't want this place. And as you're standing there, you can take it without looking at it. It's yours. "Sure," I said, "It's mine." And it was perfect. (Lines 292-308)

Since the notion of acceptance of forces greater than oneself was implicit in the definition of midwifery, this philosophical construct was compatible with her and others' understanding of themselves as fit for midwifery.

This hierarchical schema describes the strategies which the informants used to assess their goodness of fit with a midwifery model of care. The one remaining aspect of this evaluatory activity concerns the **standards** according to which the evaluation was carried out.

Standards for evaluating goodness of fit.

The actual value statements that comprise the standards for evaluation are implicit within each component of goodness of fit. For example, for "being enamoured with birth" the implied value is, "I like being around birth and therefore I should be involved with it." Following is a list of the components with their implied value statements.

1. Being enamoured with birth: I like birth and therefore I should be involved with it.

2. Accord with the midwifery approach to birth and education: Midwifery promotes a better birth and matches my approach to education and birth.

3. Discord with institutionalized methods of birth and education: Institutionalization interferes with positive birthing and the kind of education that will support positive birthing.

4. Experiencing community with midwives: I am like the people who promote the style of birthing that I envision and they accept me.

5. Finding synchronicity with midwifery clientele: I get along well with the people who want midwifery care and they find me a suitable midwife to them.

6. Finding agreement with one's life: Now is a suitable time for me to learn midwifery, when I consider my own feelings, and my family dynamics and needs.

The second aspect of standards which must be made explicit concerns the derivation and evaluation of these standards. In other words, from where are these standards derived, and who makes the assessments? In the data, the informants shared five sources of evaluatory standards. These standards apply to both the informant and midwifery, by virtue of the fact that "goodness of fit" was sought between them. It is interesting to note that the sources of the standards were identical with the agents of evaluation. Each source will now be discussed individually.

1. **The informant's internal barometer.** By far the most prevalent source of evaluatory standards was the informant's own internal sense or barometer. Many would make statements like "It just didn't feel right", or "I just knew" or "I had to know for myself." The following statement by Ruth conveyed her use of this inner standard in determining that she was enamoured with birth:

> I think birth is absolutely wonderful. I would do it over and over....I just wish I were independently wealthy, and I could have ten. And I love the parenting part of it too. But, I just, I want it to be possible for every woman out there who ever has a baby to feel the same way about birth as I do. Because it's marvellous. And, it's absolutely empowering to give birth. (Lines 713-725)

This standard extended to all components of goodness of fit. The final determination of goodness of fit was always made by the informant herself, regardless of the particular aspect that was being considered.

2. **One's clientele.** The second most important derivation and evaluator of goodness of fit was the clientele. Because of the importance placed on choice and relationship, the becoming midwives placed great emphasis on acceptance according to the standards held by their clients. Irene showed how important she considered this when she described the option of clients in her program to refuse care by any given midwife:

> I know there was times when the women, you know, chose another midwife from the one that had been assigned to her. And I, I'm glad to see that. You see, I think that gives the woman power to . . . say no. (Lines 750-756)

Designation of herself as an integral component of care by her client was for Leslie a significant difference within the midwifery practice:

> I think it was a combination of the context of being with the midwives but also the opportunity to really be more with the women than that sort of being, I don't know...Some people sometimes call nursing as the "in-between" position, where you're sort of with the physician, and sort of with the patient, and sometimes you end up getting squeezed out because of being in between. You know, it's like having too much meat in your sandwich and you squeeze it, and the meat pops out. Um, and I felt that even though I was in a student role, and I wasn't the primary care giver, that I, I was more stuck to the bread...when I was in with the midwives then I was when I was in the obstetricians office. Um, that I wasn't the expendable person who could be pushed aside if there was a problem coming up or if somebody just didn't feel like having me there. It was more like there's a good reason for me to be there. This woman has now made a commitment, she wants me to be at that birth, and unless I can't be found somewhere, then I will be there. And that was, I think that was really important for me. (Lines 1400-1426)

3. **Other midwives.** A third source of standards and evaluation were the other midwives with whom the informants apprenticed or whom she encountered. This connection was often loosely defined, particularly for the earlier midwives. For those who came later, however, the ones who had come before were an important source of evaluation and standards. Emma explains:

> Initially there was an acceptance from [a midwife] that she would try to incorporate me [into the practice] and to introduce me to the other midwives, and identifying my desire to apprentice, [and] the things that I had done to get to that stage where I [was] and...going through nursing...I was committed to going through the whole thing, and I think for them, the recognition that commitment is an important part of apprenticing. And I think that probably the first four to six months...there's a period of time where they're sort of watching how I'm responding to being called out in the middle of the night, to being available, how have I worked it out with child care, so that I can be available. All of

> these things are incorporated into how they review me as a potential apprentice. (Lines 908-935)

4. **The informant's family.** The positive response of the informant's family to the style of birthing advocated by midwifery and to the informant's decision to become a midwife was also influential. Jean's mother had initially been disapproving regarding her choice to have a home birth, but her perspective changed when Jean's sister had a home birth:

> And then when my mom came over after, she didn't know that my sister was going to have a home birth, she, we'd said that we were going to the hospital with her, and when we phoned, and said, "Oh come over and see the baby," she thought, "Oh, that was quick." And then, she came over and she saw the placenta in the bowl, and my sister nursing the baby, and she figured it out. "Oh, you had it here!" And when I was driving home with my mom that night, she said, "I would have given anything to have a baby like that." (Lines 264-276)

Their partner's support was also crucial, and would at least in part be related to their considering the informants' choice a positive one. Patricia, for example, related how her husband was untiringly supportive of her becoming and being a midwife, and felt that this was directly related to his close work with her in planning their first, unattended home birth.

5. **Professional and lay literature/knowledge.** The informants' immersion in the literature exposed them to standards which they could apply to themselves. Of course, these standards were mediated by their own evaluation, but they provided a vision according to which they could make this assessment. Familiarity with the professional literature provided the informants with a standard according to which they could compare their own fitness (by virtue of their level and accuracy of knowledge) to that of others with whom they came into contact. Emma, for example, encountered less than ideal education of post-partum women in the community by some health care professionals. Her professional knowledge of this inaccuracy reinforced her sense of herself as a fit practitioner, who could provide more reliable information to the women and families in the community.

The process of evaluating and finding evidence of goodness of fit was presented as evaluating the woman's sense of fitness according to her concept of midwifery. These standards reflected two prototypes. The first was the conceptualization of midwifery which led to the decision to become a midwife. The second was the informants' definition of midwifery, which, it seems acceptable to suggest, was at this point of her becoming, in development. Although the main evaluator remained the aspiring midwife herself, there was never-the-less reference made to external criteria--an indication of both the status of learner/aspirant, and an indication of the very real acknowledgement of the relational nature of midwifery.

Evaluating and finding evidence of goodness of fit continued until the completion of the process--until the aspiring midwife became a midwife. Just as it was an integral component of the decision to become a midwife, it would also be essentially enmeshed with the culmination of these activities. This feature will be described when the exit from the process of becoming a midwife is reached. First, it is necessary to explore the other major undertaking of this process, that of acquiring knowledge and skills for midwifery.

Acquiring Knowledge and Skills for Midwifery

All informants considered the possession of knowledge and skills as the cornerstone of responsible midwifery practice--as attested to by their definition of a midwife as educated. For each informant, the acquisition of knowledge and skill began differentially both prior to and after the conscious decision to become a midwife, and they exhibited a wide range of skills at that time. Those who had accumulated a considerable amount of knowledge and skill prior to this point spoke more about developing the other facet of becoming a midwife (i.e. evaluating and finding evidence of goodness of fit) in the active portion of the process. Indeed, it was in the analysis of those transcripts that the category goodness of fit first became apparent. Those who had at time of interview acquired little or no knowledge and skill were most articulate in describing how they were pursuing their goal of skilled, knowledgeable practice. In other words, those still engaged in this pursuit were most definitive about its structure and details. The importance placed on the acquisition of knowledge and skill was also differentially felt: those who began with more tended to consider goodness of fit more vital, and those who began with less tended to place more value on knowledge and skill.

Acquiring knowledge and skill (AKS) was not intimately connected to the point of entry in the same way as were discovering goodness of fit and conceptualizing midwifery. Rather, the informants saw AKS as the explicit work of becoming a midwife, the bulk of which usually took place after one decided to become a midwife. When this work began prior to the point of entry, it was viewed differently, and was not as consciously informed by the future midwives' sense of goodness of fit, though vague feelings of discomfort were becoming apparent. **Within** the active process, AKS became intimately connected with goodness of fit. This relationship will become clear as the description of this process unfolds.

Three parameters broadly define AKS: what is learned, how it is learned, and where it is learned. The first of these, what is learned, concerns the **content** or actual composition of the knowledge and skills sought and accumulated, and is a direct reflection of what the informants considered essential knowledge and skills for midwifery, as delineated in the definition of midwifery. It can be further subdivided in two ways, in terms of the **type** of knowledge/skill, and in terms of the **subject matter** of the knowledge/skill.

How and where the knowledge and skills are acquired constitute the strategies for and conditions under which AKS takes place. These are intimately interconnected, and can be further subdivided into two dimensional levels, both of which contribute fundamentally to the structure and content of the learning environment. The first dimensional level is a broad, general set of conditions and strategies and consists mainly of the selection of and enrolment in appropriate and available learning programs. This level provides the framework within which the learning takes place. The second is an immediate, particular set of conditions and strategies, and describes the individual, day to day character of learning which occupies the larger framework. Although there is a clear suggestion of temporal relationship between these two levels, (first one chooses one's program, then one fills it in with learning) in fact there was continual reflection upon the ethos of the learning taking place within these boundaries, and a constant evaluation and at times adjustment of those parameters, both as informed by one another and by the "goodness of fit" dimension. This resulted in a dynamic, individualized learning environment. These parameters of AKS will now be fully described.

What is learned: The content of AKS.

1. **Type of knowledge/skill.** The informants identified three types of knowledge and skill, or ways of knowing, as relevant for midwifery. These were theoretical, subjective/intuitive and practical. Theoretical knowledge was considered to be that which was learned from books--such as the principles behind practice, anatomy, physiology, and research findings. It is primarily factual and abstract, at least as it was learned. For example, learning the anatomical structures of the maternal pelvis from a book would be considered theoretical learning and knowledge, until such time as it was applied and affirmed in practice. Practical knowledge and skill was indicative of "knowing what to do with your hands", as well as the knowledge that comes with long familiarity with labour and birth--"knowing how to read labour", for example. Subjective and intuitive knowledge and skills have been grouped together because there was not a clear differentiation between these two ways of knowing in the data, and both are primarily interactive. Subjective knowledge for the purposes of this thesis includes knowledge both of the personal, individual experience of the client and of that of the midwife. It is heavily laden with emotion and values, and includes knowledge which presents itself from no clear source. It is in this latter definer that it overlaps with intuitive knowledge, and hence the grouping subjective/intuitive.

Though with individual variations, the informants considered all types of knowledge at least desirable, usually important, but not always imperative. Ruth reflected a common perspective when she underscored the need for both theoretical knowledge and practical skills:

> Well, all the theoretical stuff is important....And I use it a lot, I use a lot of the knowledge I have. And I really do try to keep up to date on the research and stuff. But I think the very most important knowledge that's out there is really practical hand's on experience. (Lines 189-198)

Irene repeats this emphasis on practical skills, and distinguishes them from technological skills, which she and others identified as a potential threat to midwifery:

> I think a bigger threat [is] the midwives dealing with technology. You know, not to get stuck with that, and lose the skills in their hands and their intuition.... But more the skills that you have, like you start depending on the fetal heart monitor, you know, you stop trusting yourself, and how you feel about the birth, I think those are the things that are more important. (Lines 494-503)

Intuitive knowledge and skill was considered by most to be valuable but not essential. In valuing this type of knowledge, most practitioners considered themselves to have some access to it, as Irene further suggests, "I think most people have it. It's a question of learning to find it. And listen to it. Trust it" (lines 2084-2086). Leslie portrayed a common affinity for subjective knowledge and skill when she indicated that she wanted to know "what is it like to be pregnant, what are your concerns at this point, what are your experiences at this point, what are the things you're thinking about in the future?" (Lines 837-841). The expression of these three ways of knowing will be clarified in the coming section, in which the **subject matter** of the knowledge desirable for midwifery will be explored.

2. **Subject matter of AKS.** The definition of midwives as educated indicates the need for the acquisition of knowledge and skill, as noted above. The other parameters by which the informants defined midwifery indicate the areas in which this knowledge and skill must be acquired--the **subject matter.**

Therefore, if a midwife specializes in normal birth, she must have theoretical, practical and subjective knowledge about and the skills necessary to assist with a normal birth. If being a midwife has socio-political implications, then a midwife must have the knowledge and skills to cope with the ramifications of that circumstance. The autonomous midwife must have adequate knowledge and skill to be the sole professional attendant at a birth. Lastly, if a midwife believes that the midwife/client relationship has a profound effect on peri-natal outcomes, then it behooves her to have theoretical knowledge, subjective skills and knowledge, and practical knowledge about the dynamics inherent in relationship building. Indeed, the specific skills and attributes mentioned by the informants can be further defined according to the type/s of knowledge that they reflect, and according to the domain in which they belong. The following are some examples:

1. **Counselling** requires theoretical, subjective and practical knowledge and skill and is required for a special relationship.

2. **Keen observation** requires theoretical knowledge to know what one is looking for, practical skills for assessment, and subjective/intuitive knowledge and skills in order to provide a complete picture of that which is being observed. It is required for promoting normal birth, to manage the effects of the socio-political environment, and to maintain autonomy.

3. **Acceptance** requires theoretical awareness of the necessity and effect of acceptance, the subjective belief that it is desirable, and the practical skill to convey and maintain this attitude. It is particularly important to the maintenance of a special relationship.

Other skills mentioned by the informants included educating, providing guidance, being able to deal with problems, giving support, facilitating, sensitivity, self-reliance, patience and reliability. The kinds of knowledge required for each of these and the domain to which they apply should be self-evident. An exhaustive list of the knowledge and skills required for midwifery was neither sought nor obtained, since it is clearly beyond the scope of this research. However, the data has yielded a satisfactory general outline of the knowledge required of midwifery. It follows that one next explore where and how this knowledge is acquired.

Where and how knowledge and skills are acquired: The conditions and strategies for AKS.

1. **Broad, general conditions and strategies.** As mentioned above, the conditions under and strategies by which knowledge and skills were acquired can be described according to two dimensional levels, the first of which is a broad, general scope. This dimension can be further subdivided into two major sub-categories, intentional and serendipitous. The intentional sub-category consisted of those educational opportunities already extant within the community or created by the informant in conjunction with others in an explicit way, and were consciously accessed with the explicit purpose of acquiring knowledge and skills for midwifery. They constitute both the conditions under which knowledge and skills were acquired, once the informants were actively participating in them, and the strategies they employed to find that learning, but in a broad sense.

The serendipitous circumstances that the informants described consisted of those various life events that impacted the becoming midwives' learning. This latter is an extremely broad sub-category, because most of life impacts on one's learning to be a midwife. However, because they are serendipitous, they cannot be said to truly constitute strategies on the part of the informants, but they certainly are conditions under which knowledge and skill are acquired. Both intentional and serendipitous circumstances will now be fully described.

a. **Intentional programs.**

Making the choice. The choice to become a midwife required an initial decision regarding the method by which the individual would actualize this goal. In other words, how was she going to become one? The informants initially came to their decision by one of two routes, or a combination of these.

First, many sought and received advice and assistance from practising midwives. Ruth, for example, contacted the practising midwives by telephone, and was directed to the pursuit of a nursing program. Access to and immersion in the "birthing culture", which facilitated useful connections, was instrumental in this process. Second, several made independent decisions regarding their approach to obtaining education, particularly those who were among the first to seek education in midwifery. Often they became acquainted with the program they eventually chose in the professional and lay literature.

Occasionally, the informants' first attempt to access education was unsuccessful. Irene, for example, investigated the possibility of apprenticeship, but was unsuccessful in obtaining one. Subsequently she successfully pursued education in another country where midwifery was fully recognized. Most informants actively combined programs, either because one program was patently insufficient, as in the case of nursing, or because their initially chosen program did not fully meet their expectations and standards. An example of the former was Emma's meshing of nursing and apprenticeship and Alana's sequencing of labour coach training with apprenticeship. An instance of the latter is Jean's decision to replace the internship offered by her midwifery program with one that she arranged privately and independently.

Several factors impinged upon the choice of program. First, availability and accessibility often forced the choice of related rather than central programs, such as nursing or labour coaching as opposed to an actual midwifery program. Secondly, cost and financial resources had a determining influence. Frances, for example, hoped to access a post-nursing midwifery program outside of Canada following completion of her nursing diploma, but was unable to do so because of inadequate funding. Jean, in contrast, was able to liquefy assets in order to attend her out-of-Canada program. Third, the informants weighed the extent to which the program meshed with their lives. Factors that required balancing included career goals (combining higher education with midwifery) and family responsibilities. Irene accessed a program in a city where she had a network of friends, from whom she expected a degree of social and personal support. The degree of family support, particularly partner, was significant since several informants' programs required extensive travelling and for two involved actually moving to another country for the duration of the program. Transfer of the informant's partner to a city where programs were available was fundamental to two informants' decisions. The fourth and final factor that influenced the informants' decision was the goodness of fit filter. Indeed, this filter can be identified in all the preceding factors, and once again formed the essence of the decision-making process. Therefore, the becoming midwives' assessment of the available programs, and whether they meshed with their sense of fitness, as has been previously described, would be a factor which impacted on their choice. At times, of course, compromise was unavoidable, since there was little available in the way of midwifery education. Emma explains:

> And, I ... tried ... to find a way out, to not go [in]to nursing, 'cause nursing wasn't at all what I [wanted to do]. And I knew that before I went into it, that it was not what I wanted to do, but ... In many ways it's so irrelevant to what a midwifery program would--or, let's say, something related to midwifery would be. The two areas are so distinct. (Lines 403-417)

The choices. Intentional programs included those programs of learning which were generally available within the community, as well as those arranged specifically for the particular individual. The following is a description of those resources enlisted in the pursuit of midwifery education.

Three informants undertook a two-year nursing diploma for the explicit purpose of acquiring knowledge for midwifery. (Three others also had prior nursing education, but their's was undertaken prior to their decision to commence midwifery education). As alluded to previously, nursing was considered a sub-optimal means of acquiring knowledge and skill, but provided the easy, affordable accessibility which the informants valued. For these women, it offered the only structured learning environment which was in any way related to midwifery. That structure was valued by those who accessed it. Frances explains:

> I really think that it's harder to become a midwife without some kind of formal class, and I don't think it has to be nursing, but I think that those people who actually sit down and help with those kinds of things [really help]--it's a lot easier than just doing all self-study, and working with a midwife. (Lines 297-303)

All of these informants sought additional learning resources, two primarily in concurrent midwifery apprenticeships, and one primarily in a subsequent physician's practice apprenticeship. Clearly, they deemed nursing insufficient as a sole source of learning for responsible midwifery practice.

As has been well described previously, nursing education also presented the uncomfortable problem of discordant information and values, thereby introducing the need for unlearning what had been previously learned or of deciding what, of that which was presented, should be retained. It was in this interaction that the "goodness of fit filter" was actively used to assess and either accept or reject the learning that was offered.

Three informants attended post-RN midwifery/advanced practical obstetrics programs as part of their midwifery education. The informants expressed some frustration with the ethos of these programs, particularly with the perceived intervening medical/nursing approach and the extraordinary demands that were placed on the students. Like nursing, these programs were considered insufficient as the sole means of education by two of the three concerned, and were actively combined with individualized apprenticeships.

Two informants undertook direct entry/lay midwifery programs offered in another country. One of these was in the form of a correspondence course, and was designated as ancillary to active apprenticeship. Indeed, this informant did not regard this program as her primary means for acquiring knowledge and skills for midwifery. The other was a residency program in the traditional sense, and necessitated moving to that country for the duration of the program--usually one year. This program, more than any other described in this study, was closest to being any informant's single source of formal learning. And yet even this program was actively added to and changed to suit the student's needs and her sense of goodness of fit--she attended extra births, and eventually, together with other students, arranged her own internship in the community. Upon completion of this program, however, she considered herself a fully-fledged midwife.

All but two informants availed themselves of some form of apprenticeship. These apprenticeships differed in many ways--indeed, all were individualized and unique as only apprenticeships can be. The earlier midwives, who constituted two of the informants, found an apprenticeship in a physician's home birth practice. All others obtained apprenticeships with practising Alberta midwives. For some, this apprenticeship constituted their major formal learning program. For others, it represented the final portion of their education, and embodied those aspects of their education which they had perceived as lacking in the balance of their education. For example, several informants noted that only here were they able to access learning which was largely consistent with their sense of goodness of fit. Other informants situated their apprenticeships at various points along this continuum of centrality--each being different from the others.

Most apprenticeships emerged gradually, and followed some degree of immersion by the aspiring midwife in the home-birthing milieu. Many had been active in the home birthing movement as, for example, labour support professionals, educators, or simply as friends of midwives. An important component of acceptance as an apprentice was the demonstration of commitment. Emma described the beginning of her apprenticeship:

> You know, going through procedure--even the preparation to get through nursing was a big struggle for me, because of my history of, um, high school, so that for me was a really good comm-- I was committed to the process--to going through the whole thing. And I think for them, the recognition that commitment is an important aspect of apprenticing. (Lines 916-923)

Irene had initially been refused an apprenticeship, and therefore sought out and attended a post-RN program. Upon completion of that program, however, she spent some time with the community midwives in what she considered to be her final apprenticeship. While this period did not greatly increase her level of knowledge, it gave her an understanding of the social climate in which women give birth.

Several other ancillary courses were accessed by the aspiring midwives, both prior to and concurrently with their primary program. These included post-secondary anatomy and physiology courses, community CPR courses, both adult and neonatal, labour support courses, conferences, and more or less loosely arranged midwifery study groups. More detailed description of how learning occurred within the programs will be considered later.

It is abundantly clear that the informants sought out and utilized what they felt they needed, even in the absence of recognized education in Alberta. There is however, another important way that the aspiring midwives acquired knowledge and skills for midwifery, which did not require or result from this intentional pursuit. This is the **serendipitous** procurement of knowledge and skills.

b. **Serendipitous learning.** As has been noted in the category discovering and evaluating goodness of fit, all of life was enmeshed with the process of becoming a midwife. However, while the informants were prolific in their description of how life experience contributed to their sense that they were fit for midwifery, they tended to view the acquisition of knowledge and skills as being something more explicitly connected to intentional, formal learning. Reference to serendipitous learning of skills and knowledge was therefore scant, and would more often be related to understanding and deepening the level of knowledge, than to explicit learning of discrete facts or skills. Lynn explains:

> ...I got my basics [in the post-RN] program, but a large part of my learning after that was learning faith. You know, trust in the body,

> trust in a power greater than the medical system, um, acceptance. And that was probably a lot of my working with death through those years, you know, acceptance that we aren't the ones in control. (Lines 1325-1333)

Often this serendipitous learning was connected to one's own experience of giving birth. Emma describes this experience for herself:

> ...a big part of my apprenticeship was having my own kids. For me...in many respects **I understand**...It really helps me to understand why it's so important for women to give birth in the place that they feel the most comfortable. (Lines 575-582).

Other references to serendipitous learning were more nebulous, and prohibit more explicit development of this category. It seems admissible to suggest, by virtue of these nebulous references and by virtue of the informants' definition of midwifery, that the contribution of serendipitous learning is greater than that which is evident from these data. As mentioned, the informants defined midwifery as being enmeshed in their whole lives: their delineation of the multi-faceted relationship which allowed a more holistic involvement by the midwife foreshadowed the inclusion within practice of skills developed from one's whole experience. Indeed, this phenomena was referred to by Ruth when she suggested that theoretical knowledge was necessary but insufficient for midwives (Lines 189-198, see page 34 CONFIRM THIS LATER!!! of text).

The broad conditions under which learning took place have been described. Within those environments, learning in the particular ensued, by way of a number of diverse modalities. These will now be described in greater detail.

2. **Specific conditions of and strategies for AKS**. The informants told of a number of specific, particular circumstances in which knowledge and skills were acquired. Most of these pertain both to conditions and strategies, as shall become clear as the description unfolds. First, several components of the learning environment were seen to give direction to the learning, both in terms of the manner in with the learning took place, and the actual nature of the knowledge/skill acquired. These components were a) oneself; b) the woman/client; c) the nature of birth, and d) one's teachers and learning

community. Second, the acquisition of knowledge and skill can be described according to its temporal relationship to the actual practice event, namely as being anticipatory, situation-driven, or retrospective. Finally, the informants spoke about the actual nature of the learning experience as being a circular activity, which synthesized theory and practice. All these elements will now be fully described and illustrated with the informants' words.

a. **Direction of the learning.**

Oneself. The particular type of learning of which the aspiring midwife availed herself can be categorized according to who it was that determined the content and process of that learning--in other words, the director of the learning. By far the most important director of learning in this group was the learner herself. The student would follow her own sense of what and how she wanted to learn. As can be surmised, this self-direction is intimately connected to goodness of fit--the learning process and content was continually evaluated according to the aspiring midwife's sense that it was in accordance with her perception of what midwifery should be. If the learning did not mesh with that perception, it was not necessarily abandoned, but other forms of learning were sought out to balance that which was seen as less than ideal. In order to be self-directed learners, the informants recognized that the ability to learn on one's own was imperative. Ruth:

> I'm very much a self-motivated learner...I did a lot of the theoretical work long before things ever came up in practice, so that I had a good theoretical knowledge before I went to [actual births], which made it very easy for me to pick things up when it did happen in actuality. So, I didn't have to be taught a lot of things. (Lines 587-597)

Self-direction was also clearly evident in the search for evaluation. The students valued the input of more senior midwives (as shall become apparent below), but regarded themselves as the final authority on their learning needs. Emma spoke about the vacillation between ability and assigned tasks, and how she sought to rectify the disparity through the active solicitation of evaluation:

> There were times when I felt I wasn't ready for things, and there were other times when I wanted to do things, that I felt that I was ready for, and wasn't able to do...And then there was a point where, when we would discuss, you know, we'd sort of talk about--I was looking for an evaluation, and we talked a little bit about how they felt I was doing. (Lines 956-974)

Self-direction was, by simple virtue of the relative flexibility, more evident in more loosely structured programs such as apprenticeships. However, even in structured programs, the students endeavoured to maintain a sense of control and self-determination. Jean, for example, unlike other students in her program, actively sought to watch more births than were required:

> I probably saw fifteen more than that, because during my training there was also an anthropologist who was studying bonding. And so she put in a one-way mirror in the birthing room...and if ever a birth was going on and it wasn't my turn to be there, I would always watch with her in the back room, so I saw more births than most people could, people didn't do that. (Lines 333-346)

At times, some informants' self-direction was temporarily forfeited in exchange for learning. Irene described the ethos of her very directive program:

> I think it's hard, because you find yourself in a student role after being totally independent, and thinking you know things, to be totally stripped...And they really did that to you, you know, you were totally scrubbed off, you felt like a new born, and you stood there and said, "Please, what am I supposed to do, I know nothing." 'Cause it was a totally new experience for most of us. And, uh, the humility and the strength that you kind of have to have at the same time to rise from the dirt and to get through it. (Lines 682-696)

Woman/Client. What, how and when the learning takes place was also inextricably bound up with the client, and with woman/relationship-based practice. The informants asserted frequently that the way one approaches the labouring woman determines what one learns, and that "You learn from the women, Alice!!!" (Frances, line 274). It is important to note that the decision to learn from one's clients is one that clearly emanated from the learner herself--therefore, learning directed by the woman is at least in part the result of self-directed learning. When asked if opening up to the women in her care influenced her learning, Leslie responded:

> Yeah, and certainly I would say that the women themselves were probably far better teachers than anyone else. Although no one formally ever wanted to teach me anything. (Lines 861-865)

This is an approach that gave primacy to the experience of the woman, and only secondly sought to meet the learning needs of the student. Alana explained how the needs of her client influenced her active learning:

> The lady had a little bit of a tear, and I don't feel confident to do suturing yet, but, it was a bridge crossed at that same birth, because it went from almost finding that the most distasteful part of the job I was going to have to learn, to-- that lady shouldn't have had to go to the hospital, you know. I should have been able to do that for her. So, it kind of gave me the encouragement to go ahead-- that's sort of a necessary skill that I need to learn. (Lines 349-359)

Once again, learning as directed by the women was influenced by goodness of fit. Because the reason for considering oneself fit for midwifery was fundamentally related to woman-centred practice and acceptance by one's clientele, it followed that the process and content of learning was intentionally deferred to the wishes, needs and decisions of that clientele.

The nature of birth. Some informants spoke explicitly about fitting their learning to the nature of birth. Therefore, if birth is spiritual, one needs to be sensitive to spiritual things. If birth is intimately connected with relationship, one learns in a relational way. If birth is an intense experience, then education for birth is also intense. Irene, after describing a very intense birth in her program stated that, "they knew there's no way you can, you don't ease into it. I mean, birth is so dramatic as it is, you might as well take it for what it is" (Lines 715-718). As noted previously, the **content** of the learning was explicitly related to the learners' beliefs about birth. Here it also becomes clear that the students believed that the **process** of the learning was directed by the nature of birth.

Teachers and learning community. The final source from which the students sought and/or found direction was teachers and/or professionals, particularly midwives. Direction from professionals took several forms: control, guidance, modelling and mentorship. The degree and type of control was largely dependant on the type of program in which the learner was engaged: traditional, established programs manifested a large degree of control, and loose apprenticeship programs provided considerably less. Irene's description of her program above (page 116, Line 682-696) is indicative of a great degree of control by teachers. Emma, in contrast, expressed frustration with the absence of external criteria, thereby revealing the scarcity of direction, in the form of control or guidance, from senior midwives:

> Lots of times I was really frustrated not having anything to attach myself to, in terms of a point, where am I, am I half-way through, am I close to the end, am I at the beginning? ...And I think that's one positive thing about instituting a program, that it'll provide people with [external criteria]. (Lines 1059-1067)

Most informants recognized the interplay between control and flexibility, and acknowledged that the two were to a large extent at odds with one another. This dichotomy required the active involvement of the learner to bring a sense of order and direction to their learning, a phenomenon which Emma's comment confirms.

Guidance was actively sought by the learners throughout the learning period, in much the same way that they sought guidance regarding the choice of their education. Implicit within this request for guidance is both a respect for the greater knowledge of the teacher, as well as a desire on the part of the learner to optimize her learning opportunities. Alana described her strategy:

> Whenever there's conferences, then I would sit down with [MIDWIFE], and go through them, and say, "Okay, based on the level of skill I have now, you know, where do you think my time would be best spent, as far as these workshops go? I know this is where my interests lie, but you know, where do you think my time would be best spent?...Kinda look to her for guidance, as far as that goes. (Lines 271-281)

Other areas in which guidance was sought from teachers included advice in practice and direction in reading and study.

Although most denied actively emulating role-models, there were elements of modelling evident in some descriptions. The distinction is that while no informant identified any specific midwife or other health professional that they regarded as encapsulating fully their ideal of the perfect midwife, the learners actively paid attention to every health professional they encountered, and selectively adopted practices, attitudes and knowledge from each. Jean demonstrated this selectivity as she described the director of her program:

> She was a really good teacher during the classroom study, she was totally in front of it, she always had [experienced] everything that you came across in a midwifery text...and she could tell you the story, and so you [would] remember everything, 'cause you could relate to her stories. But, um, as far as during the actual births we felt a lot more relaxed when she wasn't there...The director was a role model, because of her experience, [but] I didn't want to be just like her, or anything. (Lines 475-570)

Other learners spoke about learning from physicians, particularly if their practical experience was largely in a physician's practice, but would not label that as midwifery and rarely as behaviours that they could model. Watching midwives at work was an important precursor for modelling, and those who had this opportunity took full advantage of it. There was a significant group of learners who were denied this opportunity--namely those who became midwives earliest in this time period. Patricia reflected a common experience for these learners when she said:

> Well, initially I didn't even know that anything really existed, except for the books. Raven Lang, but I never met her, I didn't really know her. Um, and then eventually Spiritual Midwifery came out, so you know, Ina May Gaskin was somebody that I really respected, and looked to, in a sense, although really, not much communication. Um, really for the first while I really did feel completely alone. (Lines 1602-1613)

Like modelling, all but one informant denied a particular mentor. However, indicators of mentoring were present in the provision and facilitation of learning and practice opportunities. Leslie, for example, told of a senior midwife who actively solicited opportunities for Leslie to attend her clients' home births. Without this kind of facilitation, gaining the necessary knowledge and skill would have been problematic for many of the learners, though not impossible. Indeed, the absence of mentoring did not deter those informants for whom it was not available, as evidenced by Irene's search for an alternate program when she was unable to find a mentor who would facilitate an apprenticeship with a community midwifery practice in Alberta. One wonders if it did deter others, who of course would not appear in this study, and if one of the descriptors of this group of midwives was their determination to succeed in the face of minimal support.

b. **Temporal relationship of learning to practice.** The second way in which AKS was described by the informants was according to the temporal relationship between learning something and its appearance in actual circumstance. Learning about some aspect of midwifery took place in three time frames: prior to (anticipatory learning), at the time of (situation-driven learning) and following its appearance in practice (retrospective learning). Each of these will now be examined.

Anticipatory learning. Anticipatory learning of knowledge and skill occurs in anticipation of requiring that knowledge and skill in practice. It is very likely the most common kind of learning, and generally considered ideal: one should have knowledge and skill firmly in place (at least in one's mind) in advance of needing to draw on that knowledge and skill in practice. Alana explained how she prepared for a birth that was expected to be somewhat different than the ordinary:

> We just sat down the day before, and we went through every scenario we could think of. Okay, if the baby needs resuscitating, what do--who will do what? So we're not deciding at the time. You do this, you do that...We laid it out, we had all the right equipment and everything set up, and, uh, we felt really confident then that we could handle whatever happened. You know, we sort of set guidelines and a framework for ourselves, and worked within that, and that was fine. (Lines 1116-1132)

Generally, practical skills and theoretical knowledge were acquired in rehearsal learning. As above, it could be carried out in co-operation with others, but was also frequently pursued in solitude. Indeed, most informants regarded the ability to access learning with minimal input from others a necessary skill.

Situation-driven learning. The second time frame in which learning took place was simultaneously with the appearance of the phenomenon in practice. For the purposes of this study, this will be termed situation-driven learning. Both informants in formal programs and apprenticeships made reference to situation-driven learning, though it was spoken of more positively by those in apprenticeships. There was also a clear differential in control over situation-driven learning between these groups: those in formal programs felt that their learning was more driven by their instructors, and those in apprenticeships more driven by the nature of birth, their clients and themselves. Irene spoke about feeling prematurely forced into situation-driven learning after what she regarded as insufficient rehearsal learning:

> 'Cause they really pushed you, they just said, "Do it." Go in and do it. I mean, [like with] prenatal classes, "These are your clients, go and teach." "Okay." But I mean, it was good. I mean they gave you some background, and then they kicked you. Said, "Go do it." And you just stood there, you were shaking, you were sweating, and then you do everything. You just have to, but you learn fast. (Lines 702-710)

Others, in contrast, spoke more comfortably about the interplay between practice and learning:

> ...of course there were the births that the doctor didn't make it to, and again, I gained my skill, and got more comfortable with being in a primary role. And doing the actual delivery. (Patricia, lines 778-783)
>
> But I find each birth that I go to, it, there's something sort of new that I learn, and then I kind of research that, in all the books that I've got, even though I've already gone through it once. I mean, [after that] it's really solid in my mind. (Alana, lines 368-374)

In addition to the actual acquisition of knowledge and skill, situational catalysts frequently led to changes in status on the part of the learners. Such changes would serve to enhance opportunities for skill and knowledge acquisition.

Emma explained:

> ...There's so few of us, so there were times where, for instance...about a year after I got started...[that] I worked solely as secondary to [one midwife] because [the other midwife] was on holidays. And there was nobody else, so that was fine, that was a really neat experience, and that's when I sort of went over to the other side, [and] we both realized that it was time for me to be doing more. (Lines 1007-1018)

Retrospective learning. The third time frame in which learning transpired in relation to practice was following an event, or retrospectively. Phenomena that had come up in practice were actively examined and researched in retrospect. Alana disclosed the relationship between situation-driven and retrospective learning in the following description:

> We often learn based on the most recent birth. You know, what happened at this birth, let's evaluate it, let's talk about it. You know, what was the problem, or the biggest concern in that situation, how was it handled. And that works. That works for picking up a lot of information. (Lines 392-398)

Irene emphasized reflection as the foundation for developing the kinds of relational skills that are essential for midwifery practice:

> But I think too, you know, with midwifery, it's not [that you] just go to learn [facts]. That's the foundation, but there's so many other skills, like life skills... I think you can [learn a lot] in just asking people, [and] you know, go home, ask yourself, who am I, what am I doing, what am I trying to achieve by doing this? What is my role as a midwife?...How do I act with people, am I very domineering, am I very aggressive, am I very patient? I mean, just take a peek at yourself, you know. (Lines 2270-2282)

As is abundantly clear from the various excerpts of data, the temporal distinctions are in no way mutually exclusive: a learning episode could be retrospective to one practice incident and anticipatory to another. Rather, there is an organic wholeness about the learning, within which a range of somewhat distinct temporal features can be identified. The richness of this phenomena is demonstrative of the unrelenting determination of the learners to access, and indeed create, diverse learning opportunities and to optimize on those opportunities.

These time-frame descriptors provide a framework for the learning process. However, it is clear from these excerpts that a description of the internal learning process can be culled from the data. A delineation of this enterprise, as disclosed by the informants, will now be offered.

c. **The Learning Process.** The aspiring midwives regarded the pursuit of knowledge and skills for midwifery as qualitatively different from any that they had previously sought. Unlike the latter, which had been carried out according to an external standard to which little or no loyalty was owed, the learning for midwifery was highly self-motivated, and stringent internal standards for adequacy and sufficiency were continuously and scrupulously monitored. Alana shares this perspective very well:

> I've always been one of the kind of students that could ace any exam, but don't ask me two days later what one of the questions was. I mean, I was an honours student all through school....I can cram all night, give you all the right answers the next day and then promptly forget them! I only needed to do it long enough to get it on paper, then they think you know it, and then it's great. So the apprentice system is ideal for someone like me, 'cause [it helps me retain it better]. (Lines 332-346)

Facilitating this goal of superior learning was a clearly circular learning strategy, in which the learner turned outward to acquire facts, understanding and practice, turned inward to reflect on and synthesize her learning, and then turned outward again to pursue more information, understanding and experience. This was a repetitive process, in which each circular element was connected to and progressive with others, thereby resulting in a spiral learning configuration. The learning was generally described as evolving from the simple to the complex. Emma described the beginning of such a progression:

> Well, initially, it was as [the midwife's] apprentice, so you'd come along as an observer, and...as you get used to how things run, then you're able to sort of see where things need to be done, even if it's just something as simple as putting towels in the oven, or getting hot water, or putting [out the] oil, or whatever. (Lines 994-1002)

The essence of the learning process was described and named by the informants as encompassing three steps: a) taking in information; b) putting your hand to it, and c) making it your own.

Taking in information. The initial step, taking in information, concerns the accumulation of information through a variety of techniques, most of which have been alluded to previously: reading, discussing, and observing. Though this may initially appear to be a passive step in the process, it is indeed very active, as it was in finding programs in which to learn. The learners intentionally sought out opportunities to gain information. Two groups of strategies or approaches for taking in information were disclosed in the data: a directive/deductive approach, and an open/inductive approach. The directive/inductive approach involves learning as it is generally recognized: the accumulation of facts from books, classes, and observation. It is a "recipe-driven" approach, in that the ethos of the learning and the outcome of the learning is pre-determined by a source usually external to the learner--either the book/author, or the instructor/program. This kind of approach tends to yield theoretic and practical knowledge, and has been well described under those headings. The informants in this study were critical of this approach, in that they considered it necessary but glaringly insufficient for midwifery practice. Jean spoke about a different approach to learning:

> ...I think that the energy and attitude of labour really affects the outcome. And a lot of--most medical personnel don't have a clue that has anything to do with the overall outcome.
> Researcher: Where do you think you learned that from?
> Jean: Experience. Experience.
> Researcher: From being at births?
> Jean: Oh, yeah. And respecting birth, and feeling the energy there. And just letting it be there. And when there's a lot of activity going on, it interrupts it. It interrupts that energy and that flow of things.

This description introduces the second strategy for accumulating information, the inductive/open approach. In it, the learners actively sought to attune themselves to the essence of the experience of the woman/family and to the nature of birth. It is a phenomenologic approach, which seeks to put aside previously or externally acquired information, which is correctly perceived as being value-laden, often in accordance with a value system not the learner's own. The learner opens herself to the persons or activities taking place, and allows those activities to direct her learning, rather than attempting to direct her learning herself or following some external standard or recipe. The midwives felt that this kind of openness was fundamental to the establishment of woman-centred practice, and to the development of skills (for example relational and intuitive) which differentiated midwifery from medicine. As is readily clear, this approach is fundamental to situation-driven learning, and is an important component of retrospective learning. The inductive approach was recognized as being a source of all three types of knowledge for midwifery: theoretic, subjective/intuitive and practical.

Putting your hand to it. The second step in AKS was coined by one of the informants as "putting my hand to it":

> I learn a lot by observation, so, watching the lady labour, I felt really confident that she was progressing ... And of course, there's always that niggling doubt, am I really going to know what's going on when I have the opportunity to check. And yet, I had complete confidence, like, when I checked, I knew the exact situation, and it was like everything I had read, it was all right there. You know, and it sorta, once I sorta had my hand to it, then it's sorta solid in my mind, and...I don't lose it. I either have to use it or lose it. And it was really nice to know that all the studying and stuff had paid off, that I could accurately describe for her what was happening, and I knew what the situation called for, and felt really confident handling that. Um, so it's nice to sort of see the educational process continuing and that it is a valid process. (Alana, lines 304-331)

In this story Alana clearly delineated the progression from acquiring information to "putting her hand to it", where received/theoretic knowledge was anchored through experience and affirmation. Whereas previously the knowledge was only knowledge, at this time it was driven home at the anvil of experience--"sorta solid in my mind."

Making it one's own. Alana also introduced the third step in the learning process--that of synthesis, or "making it one's own." At this point the knowledge became integrated with the learner's former learning, and indeed with her whole concept of midwifery. Emma spoke about synthesizing her learning from role models:

> You take on your own, with time, you know, you take on your own personality, and what you feel is important, and you watch how people respond to you. But certainly mentors, I mean, oh, yeah. But now, I've sort of come around full circle to where I know where I am. And I know that, sort of, you incorporate bits and pieces of things that you learned, qualities that you appreciate, uh, seeing and having had people when they where dealing with me, and, you know, [you] become your own person. We all do that, and as we go through this whole process there will be other midwives that we come in contact with, or other people and we'll realize those qualities are [ones we wish to emulate]. (Lines 622-640)

Though the process has, for simplicity's sake, been delineated in a more or less linear, consecutive fashion, in reality there was variation in each learning episode and in each midwife's experience. There is a **degree** of linearity, since this is a process over time, but within that very broad framework individual variations exist. Alana and Emma, in the illustrations above, for example, indicated a more or less consistent pattern of taking in information, putting one's hand to it, and making it one's own. Irene, on the other hand, who was in a qualitatively different program, carried out some synthesis within the allotted time period for learning, but also made time at its completion to synthesize her learning. She considered this a necessary activity before she could consider herself an independent midwife:

> But the training was good. I liked it. Because it was fast, it was full of information. And it gave you so much. and then you kind of have to sit and digest it, you know. 'Cause they just pour it over you.
> Interviewer: And did you have to do that when you were finished?
> Irene: You did it all the time, but it would continue after you were finished too, and I think that's why I didn't think I was ready to jump into it right away, because I felt like I had to, you know, get

> things into places, and to digest and to see what I actually had learned. And put a perspective on it too, like how do I see those things that have been poured over me, you know. (Lines 650-665)

This final step of the learning process served to fully entrench the acquired knowledge and skill in the mind and hands of the aspiring midwife. By it's spiral nature, it also served to provide the opportunity for the woman to monitor the ethos of what she was accumulating, and thereby influence her active learning which would follow.

The learning process represents the final component of the category "acquiring knowledge and skills for midwifery" that was found in the data. A full description of the active components of becoming a midwife have thereby been described, with one exception. The consummation of all this work, the point at which the woman graduated from aspiring midwife to independent midwife, will now be described.

The Graduation to Midwife

At some point the becoming midwife graduated to independent midwife. It is important to recognize the difficulty of such an accomplishment when there are no recognized or established external indicators of this transition. All the informants related that it was an internal sense that signified when they became an independent midwife. Someone else's designation, of itself, was insufficient. As with the commitment to become a midwife, the informants named two factors which needed to converge in order for them to come to this self-designation of midwife.

The first factor was their own internal sense that their competence and knowledge was sufficient. Particularly with the medico-legal atmosphere such as it was, the women needed a deep sense that their knowledge level was adequate. Furthermore, this was a responsibility owed to their clients, that if one puts oneself forward as an independent midwife, then one should have the competence to support that claim. It was a question of being trustworthy.

Alana illustrated this commitment when she described why she would not yet consider herself to be a midwife:

> [I'm] an aspiring midwife....I don't want to call myself a midwife until I feel I have a certain level of competency. Until I felt prepared to really take responsibility for mom and baby's wellbeing at a birth....When I see [midwife] work, and how confident she is in situations where baby has been slow to respond, when mom's been bleeding a little bit, I think until I can feel comfortable that I can handle any situation that I might come against,...I won't be calling myself a midwife. I haven't been at enough births yet....I think until I felt like I could provide primary care from beginning to end, I'm not yet a midwife. (Lines 1004-1035)

Ruth confirmed this expected standard for self-designation as a midwife, when she confirmed that she did not feel like a midwife until a birth which she alone attended, all senior midwives having been called away to other births. It was when she knew that she was capable of meeting the challenge that she felt confident to consider herself a midwife, even though her clients and colleagues had regarded her as an autonomous midwife for some time. Irene identified this point as one when you "take responsibility for you knowledge":

> I think the rest was kind of laying the foundation. And then you have to take this final step, when you take responsibility for your knowledge. Okay, accept that you have it. And put it into practice. Just being a back-up, you don't do that. (Lines 1409-1415)

Irene noted that her first client provided the impetus for this transition:

> I was glad when she came, because I was ready. But I hadn't kicked myself hard enough to take the responsibility. She made me do it, by asking me direct[ly]. There was no way I could get out of it. Again, there was this magnet, you know. I couldn't say, "No, no, go and see [another midwife]." There was no way I could do that. She came, knocked on my door, said, "Do you want to be my midwife?" "Well, of course!" ...So somehow I think I was kind of waiting for that to come. In a sense. 'Cause it really, it just opened everything up. (Lines 1443-1455)

Irene's example introduces the second factor required for the culmination of the process--that of some kind of external recognition that the learner was indeed a midwife. When these two factors came together, the woman could say, "I am a midwife", and she exited from the process. Recognition most commonly came in the form of a request from a woman/family to be their primary midwife. Others included recognition by a political body, recognition by other midwives, and recognition by a physician.

The twin components of the point of exit flow directly from the twin processes which precede it. Competency and knowledge sufficiency flow directly from the pursuit of knowledge and skill, and once again the learner herself sets the standard for this attainment. External recognition is the final indicator of goodness of fit, particularly when the client extends the endorsement. It is the final recognition of the centrality of the relationship and the client in midwifery learning and henceforth practice.

At this point the aspiring midwife became a midwife. However, she remained a learner. Finding new and different ways of acquiring knowledge and skill remained a responsibility which the midwife owed both herself and her clientele. Indeed, those who had not accessed sources of education which typified the bulk of others' programs of learning often did so following their exit from the process. These programs included basic nursing education, post-RN midwifery programs, and midwifery apprenticeships.

This completes the description of the factors which together made up the process of becoming a midwife in Alberta prior to regulation. The arrangement of this data into a succinct, cohesive theory, as well as identification of the core category which binds the various elements together can now be put forward.

THE THEORY: BECOMING A MIDWIFE IN ALBERTA PRIOR TO REGULATION

The final step of a grounded theory research methodology is the arrangement of the data into a theory which essentially captures the many components of the process under investigation. A major facet of this theory is the identification of a basic social psychological process (BSPP). The BSPP is that single element which impacts and connects all other categories of the theory. A graphic representation of the process gleaned from these data is given in Figure 2 (page 131).

The process of becoming a midwife began early but non-specifically for these women. Hence, a funnel-shaped container depicts the activities discovering goodness of fit and conceptualizing midwifery. The open, wide mouth of the funnel conveys the diffuse nature of the woman's awareness of the qualities and concept undergoing discovery. As time goes by, the woman's recognition of her fitness and the concept of midwifery became more explicit and conscious, portrayed as a narrowing of the graphic representation. Eventually the two categories become manifested as I, which encapsulates the category discovering goodness of fit, and midwife, which represents the category conceptualizing midwifery. Prior to her fully conscious recognition of the full implication of her growing awareness of self and of the concept midwife, the woman passed through a period of indecision and loss of focus/refocusing. It was within this period of change that a new reality emerged: I am going to become a midwife. The now aspiring midwife followed this decision with activity focused towards that goal.

Following the commitment to become a midwife, a third element became subsumed into the process: that of acquiring knowledge and skills. As is illustrated on the diagram, this process was taking place prior to the women's decision, but with less direction. It was not connected to the commitment to become a midwife: no informant stated that their prior level of knowledge was key to their decision. Prior learning was actively considered and incorporated into their becoming process, however. It was key to their decisions regarding education and implicated in their assessment of fitness for midwifery. It provided the foundation on which they built their specific learning activities for midwifery.

AKS and finding and evaluating goodness of fit are depicted as interconnected spiral processes. As has been recounted in the description, the

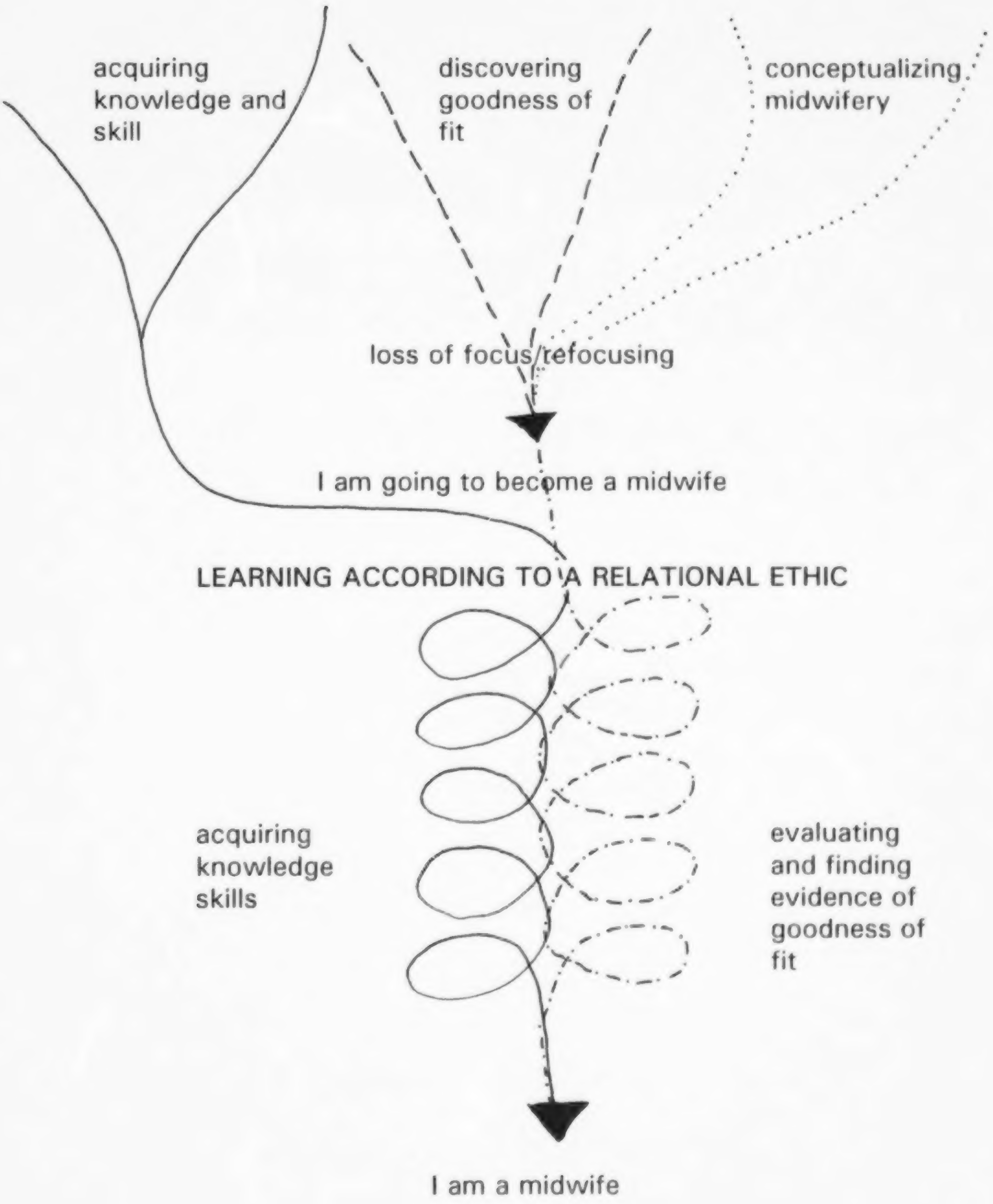
acquiring knowledge and skill
discovering goodness of fit
conceptualizing midwifery
loss of focus/refocusing
I am going to become a midwife
LEARNING ACCORDING TO A RELATIONAL ETHIC
acquiring knowledge skills
evaluating and finding evidence of goodness of fit
I am a midwife

Figure 2. The process of becoming a midwife in Alberta prior to regulation.

aspirant continuously monitored her learning and her suitability for midwifery. This monitoring took place both within and between the categories. The monitoring within the categories has been well described previously. Monitoring between categories assigned an evaluative function to one activity in relation to the other. That is, the content and process of acquiring knowledge and skill was assessed according to the parameters which constitute goodness of fit. For example, if midwifery is woman-centred, does the learning support and teach the individual to do that? The woman's goodness of fit was likewise evaluated by her acquisition of knowledge and skills--when the type of knowledge she acquired was appropriate for midwifery practice as she envisioned it, then her sense of fitness increased. As has been clearly explained in the description, the point where these two activities converge is the point where the woman could say, "I am a midwife", and she completed the process.

The BSPP which essentially defines the process of becoming a midwife in Alberta is **learning according to a relational ethic.** As shown on the diagram, this theme emerged at the point of decision, coloured the process of becoming from that time on, and was eventually expressed in the informants' definition of a midwife.

Ethics concerns the norms which guide behaviours between persons. When applied to the way an individual learns, an ethical stance will guide the **way** one should learn, **what** one should learn, and **who** is responsible for or should influence those decisions. First described by Gilligan in 1982 in a critique of earlier phallocentric descriptions of moral development, a relational ethic is put forward as an approach to moral reasoning more closely attuned to a woman's voice and experience. In a relational ethic, the moral health and vigour of the **relationship** assumes primacy over the abstract principles according to which the individuals should act, though these may be considered. The practitioner acting or learning according to a relational ethic derives her direction from natural human caring. As such, she acts according to an apprehension of the rich contextual detail in each particular situation, including the distinct identities of all the persons involved, and all dimensions of thinking, acting, feeling and relating.

The relational ethic is expressed in the enmeshing of the learner with the client and the learning. As Gilligan (1987) explains, "As a framework for moral decision, care [or learning] is grounded in the assumption that ... detachment, whether from self or from others is morally problematic, since it breeds moral blindness or indifference--a failure to discern or respond to need" (p.24). The "shoulds" of the learning are discovered by the learner in close lateral relationship with and attentiveness to her client, and are only secondarily informed by distant others to whom she may assign relevance, such as practising midwives or birth activists, and by external standards, such as theoretical knowledge and institutional expectations. An **impartial** learner is seen to be disqualified rather than favoured, due to their inattention to the special, multi-faceted nuances inherent within each particular relationship, birth, and learning situation.

Since a relational ethic involves the coming together of whole persons, it directs not only the quality of the relationship of the health care professional with her client, but also with her profession, and it is natural for her to immerse her whole self in midwifery. Hence the title of this thesis: Uniting vocation and avocation. Her work and her love are one. She could not carry out this work if that were not so.

In the process of becoming a midwife, relational moral/ethical attitudes began to develop in the preparatory period, and fully informed the active process (acquiring knowledge and skills and evaluating and finding evidence of goodness of fit) after the point of entry. The standards for both consistently referred back to the way the learner and the client came together--in how they enmesh, and in the range of knowledge and learning that was sought. If the fit is good, and if the learning honours that, then the process continued. If there were violations of that ethic perceived by the learner, then other ways are actively sought out, if possible--not always immediately, but eventually. The drive to become a midwife, as perceived from these informants, was to be able to learn in a way and to learn to provide a service that honoured the unique, whole personhood of her client, herself as a woman and a midwife, and the sanctity of birth.

The informants' definition of midwife clearly reflected those particulars which signify loyalty to a relational ethic, and indicated persistence beyond the learning process. Descriptors such as laterality, client-centred perspective, engrossment, and unique and valued relationships all typify a relational ethic as well as a midwife as described by these informants. Consistency between models of learning and practice reinforces the centrality of the BSPP, and confirms the authenticity of the analytic process.

SUMMARY

All aspects of the process of becoming a midwife in Alberta prior to regulation, as disclosed by nine informants who were or had been engaged in that activity, have been described and shaped into a grounded theory. The consonance of this theory and its component parts with other findings will lend significant confirmation or challenge. A discussion of these comparisons will be offered in Chapter Five.

CHAPTER V - DISCUSSION, CONCLUSIONS AND IMPLICATIONS

The purpose in this study was to describe the process by which women in Alberta became independent midwives prior to regulation. The researcher's goal was to record this process in a group which will likely prove historically significant and very shortly non-existent, given the rapid changes in midwifery legislation. As there is very little research in which the larger profession of midwifery is described, and given the profession's efficacy in the provision of safe and satisfying care, it was thought that this study could provide foundational data for the establishment of effective educational programs. In addition to data concerning their process of becoming, the informants shared their views on the definition of midwifery. Particular attention was addressed to the relationship between midwife and client, since this component was found to be important in a pilot interview and was evident as a critical factor in the literature review.

The findings indicate that the Basic Social Psychological Process (BSPP) **learning according to a relational ethic** described the process of becoming a midwife in Alberta prior to regulation, thereby combining the aspects learning and relationship, both of which had arisen very early in the research process. Although practising according to a relational ethic is not unique, no previous literature has been located which describes the active utilization of a relational or caring ethic in a learning situation.

In this chapter, the findings will be discussed in terms of several parameters: the concept of becoming as manifested in the process; an examination of the findings according to the theory of symbolic interactionism; the significance of the definition of midwifery, and the significance of the BSPP, "learning according to a relational ethic". Implications for education and practice will be incorporated into these discussions. Finally, an exploration of the significance of the findings for further research and limitations of the study will complete the project.

The Concept of Becoming

In Chapter II, analysis of the concept becoming disclosed a wide possible range of significance for the concept in any given instance. Within the lives of the women progressing towards self-identification as a midwife, the degree of significance is clearly that which is most prominent. For most of the informants, becoming a midwife concerned their deepest sense of self, which was called upon to offer this service. Fidelity to the process and profession required a degree of engrossment and alignment which impacted not only the informants' lives, but also that of their entire family's.

This pronounced centrality of the process of becoming recalls earlier definitions of midwives as heroines (Cox, 1973; Cust, 1990; Rowe, 1990; Smulders, 1990; Ulrich, 1990), recounted in Chapter II. It seems reasonable to suggest that a process which requires major sacrifices in the lives of the participants will manifest acts of great courage and notable dedication. The determination to resist established modes of care in the face of legal, moral and financial censure can only be supported by a fundamental loyalty to the way of being that becoming a midwife implies. Essential to this transformation is the attribute of **willingness** on the part of the person to submit themselves to the process. Indeed, the informants more often conveyed a sense that they "had to" undergo this process, a degree of involvement greater than that implied by simple willingness.

Benoliel (1993), in a description of several women who were creative pioneers in the area of women and caregiving, notes that their work was enabled by their ability to translate "their life experiences with loss and pain into creative expressions that gave meaning to their lives" (p.6). Their work combined the use of personal power with a recognition of "the importance of three factors: 1) interdependency among human beings; 2) the influence of context on choices and actions; and 3) a morality of responsibility and care for others" (p.6). The significance of these descriptors lies in the fact that these women were able to bring about innovative systems of care which emanated from a deep personal sense of responsibility, commitment and connection, qualities that are reflected in the women described in this study. Acts or lives of heroism, it would therefore appear, may be associated with the attitudes and determination common to all these women.

These accounts are in sharp contrast to those which describe the "oppressed group" status attributed to nurses and nursing. In her discussion of the dynamics between medicine (a dominant group) and nursing (an oppressed group) Roberts (1983) notes that there is "a tendency for the subordinate group...to internalize the norms [of the oppressor] and to believe that to be like the oppressor will lead to power and control" (p. 22). The subordinates' fundamental inability to become one of the dominant group (due to their irreversible characteristics, such as sex or race) leads to self-hatred, low self-esteem, and a resulting devaluing and marginalization of the unique service provided by them. The study group's determination to provide midwifery care according to standards that they themselves determined necessitated that they withdraw from the dominant care system--an act which must be supported by a depth of commitment such as that described in the becoming process above, and which shares nuances of heroism.

The commitment to undergo such a ubiquitous process of becoming underscores the need to access significant inner strength. Rose (1990) ties the experience of inner strength to the act or process of "becoming and being the combination of one's purest, most concentrated real qualities or essence" (p. 62), a description amazingly consistent with the informants' experience of becoming a midwife. Once again, it is implied that the level of allegiance to one's true self impacts an individual's ability to act in ways that not only enable their own aspirations, but those of others as well.

The prominence of the process of becoming a midwife in the lives of the learners carries significant implication for education and standards of practice, and as such may impact outcomes. In the study, high commitment and dedication translated into high standards of ethical behaviour and of learning, and it is important to ask if it is these standards that create superior outcomes, or if there are other factors that do so, either singly or in combination. As midwifery becomes more common, it will be interesting to note if there are variations to the degree of centrality evidenced in this group.

Defining attributes, antecedents, consequences, and empirical referents of becoming as they appeared in this process have been well explicated in Chapter IV. Once again, these parameters indicate a significant degree of immersion into the process of becoming a midwife, thereby supporting the level of becoming outlined above.

The Role of Symbolic Interactionism in the Research

The tenets and methodology of symbolic interactionism, which guided this research in both data collection and analysis, proved to be a sensitive and suitable framework. As Fine (1993) clearly articulates, "...the classic three premises of symbolic interactionism [are]: that we know things by their meanings, that meanings are created through social interaction, and that meanings change through interaction" (p. 64). Exploration of the interaction between experience and meaning in each informant's life resulted in the acquisition of cogent, context-sensitive data and the development of a grounded theory which accurately reflected the process of becoming a midwife in Alberta prior to regulation. At the outset, the meaning which midwifery held for each woman was solicited, and from that was drawn a definition of "midwife". From there, informant and researcher traced those interactions, to which were attributed meanings, and which in turn informed other interactions, as the learners built up their sense of self as midwife. Although there was a constant interplay between the self, the learning and the environment, as depicted by the spiral nature of the process, two points in this process represent qualitatively more significant episodes of convergence between constructed meanings. These are the decision to become a midwife, and the declaration that one is a midwife. These points depict a crystallization of the events which preceded them, and each marks the birth of a new self for the informant: one which is intentional, and one which is actual.

For these informants, the process of becoming a midwife started either because the meaning that they attributed to birth, women, children and caregiving differed from that which they encountered in the dominant system **or** because midwifery and birth held special meaning for themselves. In the preparatory phase, the experiences that evoked the meaning "I as a person am fit for midwifery", and those which explicated the concept "midwifery is all these things", converged into the point "I am going to become a midwife". At that point the individual woman assumed the role of learner-midwife, and her attention became focused on that goal. In the active phase, evaluation of self and experience for indicators that meant that the learner was fit for midwifery continued, and became interconnected with the acquisition of knowledge and skills. Acquiring knowledge and skill was carried out according to the standards that the meanings constructed for these women. All of the activities in the active phase were immersed in the BSPP "learning according to a relational ethic", because of the meaning that maintaining that standard held for these women. When the learner reached a point where she considered that her level of knowledge and skill was sufficient--according to the meaning midwifery held for her--and a meaningful other concurred, the metamorphosis into "self as midwife" was complete.

The details of this progression have been well described in Chapter IV. Of note, however, are two major areas of particular concern to symbolic interactionism, which warrant additional attention here. These are the view of the self, and the interplay between agency and structure.

The View of Self

"Interactionism pictures the self as symbolic, situationally contingent, and structured" (Fine, 1993; p. 77). The application of this perspective is clear from the forgoing overview, and from the data put forward in Chapter IV. It is clear that the self as learner midwife and the self emerging as midwife was symbolic (e.g. as encompassing a means by which the informant could effect some socio-political change for the condition of women and children). The self as situationally contingent is demonstrated by the gradual evolution of the constructs "I am going to become a midwife" and "I am a midwife" from the experiences, interactions and attributed meanings in the preparatory and active phases. The self was structured according to these same processes.

However, in one aspect informants differ from the symbolic interactionist view: that of the existence of an inherent self. Several women explicitly identified their inherent self as "midwife", and although social interaction was required to draw out the full expression of that self, they believed that its inherence pre-existed that circumstance.

This notion of the self as inherently midwife became expressed in a strong sense of personal agency--that is, in the sense that one had inherent capacity to carry out the activities in which one believed. This observation leads to the second important component of the symbolic interaction model--that of the interplay between agency and structure.

The Interplay between Agency and Structure

Personal agency must be expressed according to the constraints and supports of the structure imposed by society--both generally (e.g. North American patriarchy) and specifically (e.g. the rules in the hospital when one transfers a client). Late-modern perspectives in symbolic interactionism have reconceptualized the self from prior definitions as "reflective and cooperative" to "strategic and imaginary" (Katovich & Reese, 1993). This corrective was seen as pivotal in the ability of symbolic interactionism to encompass the challenge of post-modernism, which asserts that individual selves are often pitted "against an obdurate reality which included overpowering and often hostile societal responses" (Katovich & Reese, 1993; p. 404). For these women the role of the dominant culture and of the alternative birthing culture were significant in both hostile and supportive ways, and hence in both the expression and control of personal agency.

The Role of the Dominant Culture

The dominant medical culture both precipitated and constrained the informants' emergence as a midwife. Several women would not have pursued learning for midwifery if they had not seen and felt a great need which was not being met by the existing care system. On the other hand, in learning midwifery, they had chosen to ignore social realities and norms which "...can only be ignored by those willing to accept severe consequences" (Fine, 1993; p. 69). In so doing they played an important role in the remodelling of those social norms and structures, as evidenced by the eventual recognition and regulation of midwifery as a profession in Alberta.

It was not possible for the learning midwives to ignore the realities of a hostile medical system. The constant threat of legal challenge, particularly when considered in the light of the uncontrollable nature of birthing, was an ever-present reality. While at home the midwives enjoyed relative independence and autonomy, in hospital they were immersed in a hierarchical system which gave primacy to professionals with differing perspectives of power and birthing (Benoit, 1994). The occasional need for interventions beyond those available at home, with midwives, would necessitate transfer of the client to the realm of that dominant medical system, and force interface with a potentially hostile bureaucracy and hierarchy. Once again, these realities impacted the learners' process of becoming--in terms of the kinds of knowledge they pursued, in the level of knowledge they pursued, and at what point they felt they were prepared to declare themselves a fully-fledged midwife.

Role of the Alternative Birthing Culture

More central and sustaining to the learner's commitment to the process was their immersion in a birthing culture with which they actively sought community. At least partially in response to the threatening environment around them, midwives, learning midwives and clients developed a strong alternate social reality which supported the learner and made it possible for her to develop qualities in cooperation and synchronicity with her environment. The very essence of their learning and the reason for their pursuit of midwifery stemmed from a determination to make it possible for members of their alternate reality to realize their dream of a different birth. Once again, these social realities impacted the types of learning the women pursued--learning and attention that respected the client and the birth, learning that may be needed to protect the valued client in case of interface with a hostile system, learning ways of being that maintained the client at the centre of the birthing experience. For some, acceptance from a member of the alternate culture signified their emergence as an independent midwife.

Learning to be Bi-cultural

Considering the need for these learners to acknowledge and operate according to two very different realities, it follows that it would be necessary for them to develop roles, strengths and attitudes which would enable them to operate in both worlds. Clearly, these skills would at times be in direct opposition to one another. Conflict might arise within the midwife, for example, if in a case of transfer she continued her efforts to support her client in the way that they both valued, but was required to assume the additional responsibilities of advocacy and protection. Those attitudes and actions which would gain her respect from the dominant system, and therefore optimize her ability to be an advocate and protector, could very likely be in direct conflict with her preferred supportive activities. "Late-modern interactionists viewed acts that are coordinated in mutual tension as much as, if not more than, in mutual agreement. Such acts are completed and consummated in contexts that can prevent as well as promote an open and free flow of information" (Katovich & Reese, 1993; p. 404). The learner would need to learn to make constant decisions regarding what she shared, and what she would keep secret. It was clearly necessary for the learner to acquire the skills of a bi-cultural identity, with its many challenges and perils. The capacity for the learners to continue to operate within these constraints came from their strong sense of personal agency, their commitment to birthing, the understanding and support of the alternate culture, and their strong sense that what happened in the dominant culture was wrong.

In this discussion, the suitability of symbolic interactionism as a framework for this project has been clarified, and the emergence of the major themes from that framework have been drawn from the findings. Benoit (1994) supports the use of an interactionist perspective in the examination of midwifery:

> The interactionist perspective helps to make sense of the intricate order of historical events that [shape] the social transformation of maternity care across industrialized societies, highlighting the shifting work boundary and professional status of key players struggling to gain control of the maternity mandate in the promise of improved care for birthing families....the interactionist perspective grants midwives and birthing women a place in history as social agents who sometimes have little control over their own fate, and other times play significant roles in shaping the diversity of maternity arrangements that presently endure in the industrial world. (p. 321)

Some of the specific results of the research will now be explored.

Definition of Midwifery

The definition of midwifery arising from this research contributes to a body of knowledge regarding the nature of midwives and the structure of midwifery practice. Since there is at present only very little research into this topic, the present study constitutes a significant addition. Many commonalities were found with definitions currently extant within both descriptive and research literature. Bassett-Smith (1988) identified the process of **authenticating** as a framework for midwifery practice. She defines authenticating as "...a process that is engaged in by both midwives and birthing women in order to establish practice and the experience of giving birth as being individually genuine and valid" (p. 124). This perspective indicates a primacy of the midwife/woman relationship and valuing of the experience of giving birth reminiscent of that found in the present research. Findings in Bassett-Smith's study were identified which correlate to several descriptors found in the present research. These included relational and extra-relational outcomes, the lateral relationship, a woman-centred perspective, the socio-political nature of midwifery practice, and definition of a midwife as educated. These commonalities indicate a unity of midwifery in two different cultures (New Zealand and Alberta) and as practising mainly in two different settings (hospital vs. home), and have positive implications for the definition of an explicit midwifery paradigm.

Thompson et al (1989) developed a middle-range descriptive theory of nurse-midwifery care, using various methodologies. Their research yielded six concepts which describe nurse-midwifery care. Those concepts also mirrored definers from the present research, particularly the definition of a midwife as "educated", a woman-centred perspective and laterality in the midwife/client relationship, the socio-political implications of midwifery, midwifery as autonomous, and the midwife's specialty in normal birth, both in promotion and protection. Although some of the specific expressions of the various themes differ between the two studies, all are in some way echoed in the other.

Lehrman (1981) identified eight components of nurse-midwifery care in the antepartum and intrapartum periods, which once again show considerable reflection in the current study. Included are the commitment to build a special relationship with the client, a woman-centred perspective and lateral construction of that relationship, the definition of birth as a normal, family-centred event and the identification of normal birth as the midwife's specialty, the definition of a midwife as educated, recognition of the socio-political nature of being a midwife, the centrality of spending time, the requirement of autonomy for the midwife. Lehrman's component "flexibility" is an attribute which foreshadows the emergence of a relational ethic as the overriding factor directing the learning of the informants.

Morton et al (1991) extended Lehrman's study into the post-partum period, and found all the above elements reflected there. In addition, they found a **process** model which reflected the **active** strategies of the midwife to bring about the kind of midwifery care which they sought. Once again, there is close resemblance to the definition of midwifery generated by the informants in the current study. Lateral relationship is a fundamental element of both studies. Morton and her colleagues category "therapeutic techniques" included various strategies which were mentioned in the current study, one of major ones of which was the active spending of time with the client. Lastly, their process "empowerment" corresponds to a woman-centred perspective, the definition of birth as normal and family-centred, and implies the socio-political nature of midwifery care.

Van Wagner (1991), in a study of Ontario community midwives prior to the regulation in that province, identified three themes as prominent in the description of community midwifery practice: continuity of care, choice for the child-bearing woman, and an emphasis on childbirth as a normal process. These themes reflect the importance of the relationship, woman-centred perspective and lateral relationship, and the designation of natural birth as the particular specialty of midwifery and intimate the possibility of a relational ethic. Her research emphasized the need for autonomy as the foundation on which the midwife could establish and maintain the integrity of her practice in the face of medical hegemony and bureaucratic constraints, thereby further reflecting the definition of midwifery found in the present study. The particular significance of the similarities lies in the fact that of all other studies, the informants in Van Wagner's study carry the closest resemblance to the population in the current study, by virtue of national identity and legal constraints. However, the commonalities once again are as close to those from other countries as to the findings in the current study.

Damsma (1994) carried out a study on the experience of choosing a midwife, in which she interviewed the clients who accessed the care of the midwives and aspiring midwives who served as informants for the present study. She noted that "The midwife-woman relationship emerged as a central theme which was viewed sometimes as an antecedent reason for choice and at other times as a positive outcome of choice" (p. 99), thereby reinforcing the designation of the midwife/client relationship as being a central theme of midwifery practice. Her finding that choice constituted a major determinant of the decision to access midwifery care supports the definition of midwifery as woman-centred and as being in lateral relationship to her client. Her informants identified desirable attributes in a midwife, which primarily centred around knowledge--both the value of the midwife's knowledge base (including feminine and professional knowledge) and being known by the caregiver--once again an expression of the importance of the relationship between midwife and client. Caring **actions** of the midwife which were deemed significant were also named, and reflected the lateral, open relationship between midwife and client in the present study, the midwife's woman-centred perspective, the provision of time, the socio-political nature of midwifery and the midwife's designation as the trusted guardian of a normal, natural birth. Other elements, such as woman-centred care, family-centred care, continuity of care, deep commitment, and common outcomes of care (confidence, responsibility, a positive birth experience) are also reflected in both Damsma's work and in the current study. The consistencies between Damsma's findings and those of the present study support the accuracy of the relational model presented here, and the accuracy of the informants' perceptions of their learning and practice.

In addition to information found in research reports, the descriptive literature consistently supports the definition of midwifery found in this study, an observation which may in fact be related to the fact that most of these informants either based their practice or learning on that literature, or became familiar with it as they progressed in their becoming process. Writers such as

Gaskin (1977), Arms (1978), Harrison (1982), Cohen and Estner (1983), Armstrong and Feldman (1986), Flint (1986), Davis (1987), Kitzinger (1988), Rothman (1989), and Jordan (1993) figure prominently in the alternate birthing culture. As was noted in Chapter II, they also portray a consistent image of midwifery as woman-centred, as socio-political in nature, and as composed of dedicated, educated professionals who strive to maintain the normalcy of birth in the face of an increasingly technocratic and interventive obstetrical birthing culture.

This overview of the commonalities between the definition of midwife held by this population and those found in other research and descriptive literature suggests that midwives in Alberta prior to regulation shared their perspective of midwifery with other midwives in many different countries and work environments. This appears to contradict the assumption made at the outset of this study, that no identifiable group of midwives existed when these informants began their process of becoming, and that therefore an exploration of professional socialization was inappropriate. However, as noted earlier, this definition of midwifery was that which the informants held at the time of interview, **not** necessarily at the point when they committed themselves to becoming a midwife. That definition would be impossible to recover at this point in the process. For this reason, the common definition of midwifery in this group can be seen to rather be an **outcome** of the becoming process, and intimately involved with the sharing of literature and attendance at conferences. As such, it does support the development of a theory of the process of becoming a midwife in Alberta prior to regulation, and, given the commonalities of definition, suggests that this theory may be of use as a contrast and comparison to future studies which examine this process in other populations.

Learning According to a Relational Ethic

A relational ethic has been put forward as a distinctly feminine approach to interrelationships (cf. Nedelsky, 1993; Carse, 1991; Noddings, 1984;

Gilligan, 1982). It is suggested that women draw their ethical reasoning from natural human caring, the most perfect expression of which is the love of a mother for her child. It is initially developed in the relationship between daughter and mother--in that daughters are raised by like others (mothers) with whom they identify as role models, in an experience that is fundamentally unifying. Sons, also raised primarily by mothers, grow up with a different other (a female)--one from whom they must fundamentally separate as a role model, in order to explicitly identify themselves as male. This has been described as a fundamentally individualizing experience (Sandelowski, 1988). This developmental experience is put forward as one factor influencing the differential impact of gender on world view, and hence on the perception of appropriate considerations within the realm of ethical reasoning. Girls, by this line of reasoning, prioritize connections and relationship, while boys prioritize polarity, separation and distance.

Noddings (1984) highlights the centrality of caring (attachment) for women, and their comparative lack of concern with abstract (distancing) principles:

> But women, as ones-caring, are not so much concerned with the rearrangement of priorities among principles; they are concerned, rather, with maintaining and enhancing caring. They do not abstract away from the concrete situation those elements that allow a formulation of deductive argument; rather, they remain in the situation as sensitive, receptive, and responsible agents. (p. 42)

Many scholars and clinicians in nursing have described or called for a relational ethic as the appropriate standard for the relationship between nurse and client either explicitly (Benoliel, 1993; Bergum, 1992; Parker, 1990) or implicitly (Gadow, 1981; Parse, 1981). However, to date no **published** reference to the suitability of a relational ethic for midwifery was found by this writer, though reference to suitable **codes** of ethics were found (Thompson, 1989; Thompson & Thompson, 1987). On the other hand, the descriptions of midwifery models of care consistently reflect the principles inherent in a relational ethic. Given that a relational ethic has been put forward as a fundamentally feminine approach, it comes as no surprise that it should emerge as a guiding principle in midwifery, which originally developed and today has re-emerged as a fundamentally feminine mode of caring both in cooperation with other women and in opposition to a phallogocentric medical system.

The value of maintaining a model of midwifery as it emerged as a "deviant", or "alternative" service profession has been put forward by many writers (Benoit, 1994; Van Wagner, 1991; De Vries, 1992, 1989; Rothman, 1989, 1987; Tyson, 1991) as has the inherent threat of professionalization to the protection and preservation of that model. The concern seems to be that a particular group must either exist in opposition to the dominant medical hegemony, or be part of it. Midwifery, having re-emerged in an oppressed, gendered environment, initially provided an alternative to the dominant milieu, but in becoming legitimated, becomes vulnerable to the seduction of professional power-mongering and co-opting for alliances with other, more powerful groups. Van Wagner (1991) attempts to identify the ways in which this can be prevented:

> Despite the advantages midwives and supporters see in legislation, there is a great deal of caution about the process of establishing a legal system. Ontario midwives have been critical of the process of "professionalization", identifying themselves more as a movement for change than a profession. They disassociate themselves from many of the traditional characteristics of professionals, seeking to share rather than control knowledge and work [sic] to minimize the distance between caregiver and client. When midwives seek autonomy, it is from the control of other professionals, rather than from "lay" control. Midwives need autonomy from medicine and nursing in order to support women's autonomy and be accountable primarily to the women they serve. (p. 47)

Several strategies to prevent such an occurrence have been suggested, including avoiding regulation (DeVries, 1987), situating birth in small community hospitals (Benoit, 1994) and attending some births in the home (Tyson, 1991).

The value of the present study lies in the fact that it describes a process of becoming which arose **out of** and **gave birth to** this valued model of midwifery care. The definition of midwifery and model of the midwife/client relationship described in this study are congruent with a relational ethic. As has been previously noted, this model was determined to be the **outcome** of the process of becoming a midwife, and as findings from this research show, an outcome of learning according to a relational ethic. The processes and content of this learning, therefore, may serve as foundational principles upon which to build educational curricula which will continue to give primacy to a feminine model of care and ethical reasoning in midwifery. As such, it is worthwhile to list those principles which synthesize the characteristics of the becoming process herein reported.

Essential Characteristics of this Becoming Process

Guiding principles which can be gleaned from this research, and which will be useful in the development of future curricula are as follows:

1. The learner must be true to herself and her highest aspirations in her learning and in the care that she offers her client.
2. The learner should have a deeply felt love for and commitment to the subject matter of her learning and practice (in this case birth, women and children).
3. The learner should have access to a group of like-minded, supportive individuals, who may be either clients, other learners, or teachers.
4. The needs and wishes of people and relationships have primacy over learning opportunities in any given situation.
5. Learning should be self-directed. At times this may mean that the learner solicits advice or direction from others and/or accesses a pre-set program of learning. The point here is that the learner explicitly understands the choices that she is making and agrees to them.
6. There are many ways and means of learning, and many different kinds of knowledge to be learned. All should be given their due attention, and a place

and sufficient time for all to occur should be ensured.

7. The learner should be challenged, and not unduly protected from hardship and suffering. In this population, it was often in response to their own loss and suffering, or that witnessed in another, that the informants arose to offer a level and ethos of care generally unavailable in their community.

Traditional midwifery programs tend not to honour these principles, as stated by the informants and as reported in the few studies carried out in midwifery education to date (Davies & Atkinson, 1991; Ho, 1989). They do, however, have a great deal in common with principles of andragogy, which have been put forward as appropriate strategies for midwifery education (Mander, 1992; Ho, 1991). Knowles (1978) first put forward the principles of teaching adults, conceptualizing them as self-directed learners who drew considerably on their own experience in this process. Ho (1991) outlines the principles of andragogy as

> - an adult has a large reservoir of personal knowledge to draw on; to ignore her experience would be to ignore the person herself;
> - adults need to apply their learning and hence need to see the relevance of their learning experience;
> - adults learn best when they are actively involved in the learning process. The adult learning situation is never a matter of passive passing on of knowledge from the tutor to the learner. (p. 153)

There is also a marked similarity to the "Caring Curriculum" proposed by Bevis and Watson (1989). In a model which recognizes the traditionally gendered/oppressed status of nursing and nurses and the unique qualities and opportunities inherent in that condition, they call for the implementation of "education for freedom". Their proposal includes the following beliefs:

> - A belief in power and primacy of person and power of human consciousness, human imagination, and human spirit as inner resources and key components in teaching and learning and in health-illness outcomes.
> - A belief in wholeness, harmony, and beauty.
> - A belief in the wholeness of human and environment and the larger universe.
> - A belief in ways of knowing and teaching-learning that

> incorporate not only rational, cognitive, technical, empirical but call upon aesthetics, ethical values, moral ideals, intuition, personal knowing, process discovery, and spiritual-metaphysical dimensions.
> - A belief in the context of intersubjective, interhuman events, processes, relationships, and human-environment energy fields.
> - A belief in an ontology of evolving consciousness, human freedom, release of human spirit, while adhering to human caring as an absolute value and special way of being in education and practice.
> - A belief in world view for human destiny that is open. (p.52)

Principles and particulars for developing educational systems which encompass these ideals have been clarified as a result of the present study. Careful examination of the unique components identified in this research, and their appropriate application to the education of women generally and health professionals specifically, can promote the development of systems of care which can exist in unity with others rather than in opposition, while still honouring their individual diversity.

Limitations of the Study

Several aspects of this study influenced the type of data collected, and while these factors on the one hand enhanced the data, on the other they could be seen to restrict the results of the project. These aspects will be briefly reviewed here.

The study examined events that occurred over a time span of nearly twenty years--the earliest midwives began their learning in the 1970's, and some of those still in the process of becoming began in the 1990's. As such, there was a great range of elapsed time, with the concomitant effects of differential memory loss and the possibility of the existence of at least two distinct groups in the sample. This limitation was balanced by the benefit of including all representatives of the population in the study, to determine those broad categories which were common to all of its members.

The exclusive use of interviews for data collection limits the kind of data collected to only those opinions, understanding and memories of the informants. The use of multiple forms of data collection (such as the interview of mentors and teachers, and participant observation) would have enriched the quality and reliability of the data. The enormity of such a project would have been prohibitive.

Single interview data of each participant did not disclose the dynamic nature of the process for any one individual, other than as recalled by each informant. This limitation is seen to be balanced by the inclusion of women at various points in the process.

The most detailed description of the learning process was provided by those still immersed in the learning, and secondly by those recently exited from the process. These descriptions may therefore only apply to that group, and there may be an entirely different dynamic, which was not discovered, at work in the remaining group. Because of the broad nature of the population, this feature could not be prevented or corrected, but should be considered when reviewing the data and conclusions.

Implications for Further Research

At the conclusion of this project, the question still remains: where do the outcomes come from? Are they related to higher motivation which impacts on a higher level of practice? Does a relational style of care in itself change outcomes, or is it mediated by different learning and practice? As Morton and her colleagues ask, "Could it be that these attitudes in general help to empower and engender healing?" (p. 283). Exemplary birth outcomes in the Netherlands have been related to a relational style of practice among midwives (Benoit, 1994). This fact reinforces the possibility that these attitudes may indeed "empower and engender healing". This study provides valuable data in the pursuit of greater understanding of the structure of health and healing, but significantly more research is required, including meta-analyses of all the studies on style of care, learning and outcomes.

There are many diffuse accounts of midwifery's unique style of practice and care, but to date no definitive philosophical study or foundation for that practice. Movement towards such a work, given the reemergence of midwifery and woman-centred studies, seems timely.

The importance of establishing education which maintains the unique qualities that midwifery has enjoyed up to the present time cannot be overemphasized. Research comparing the results of this study to education in different localities and under different conditions is crucial, both for the ensurance of the provision of high quality care to families, and for an ongoing exploration of women's reality in the post-modern world.

Close monitoring of the changing nature of midwifery in Alberta and Canada is important for that same reason, and continuing study of the process of becoming a midwife will help to prevent undesirable changes in the ethos and quality of service which has been the standard in the past.

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APPENDIX A

Invitational Letter

446 RH Michener Park
Edmonton, Alberta
T6H 4M5

Dear Mary Midwife:

I am currently conducting a study into the process of "Becoming a Midwife", and I would like to invite you to be a part of this study. The goal of this study is to find if there is a unique process which takes place as a woman moves from "not being a midwife" to referring to herself as "a midwife". I expect that understanding how this takes place will help us to understand what it is about midwifery care during pregnancy that produces its remarkable outcomes. Furthermore, scholarly exploration of the dynamics of a profession elevates the status of that profession.

Enclosed you will find an information sheet which tells you about the study, what you will be expected to do, and what I will do with the information you give me. After you have read it, you may call me at 436-7918 to tell me if you would or would not like to be a part of the study. If I am not at home when you call, please leave a message on my answering machine.

If you do not get back to me within three weeks after I send the letter, I will contact you by telephone. Sometimes it is difficult for people to remember to respond, and I may wrongly assume that no response means a wish not to be part of the study. For this reason, I would like to call you to confirm your wishes.

I look forward to working with you, should you choose to be part of the study. If you choose not to, thank-you very much for the time you spent in consideration of this invitation.

Your's truly,

Alice J. Rempel, RN, BN, ACCE

APPENDIX B

If you choose, you may return this form in the self-addressed envelope to let me know if you would like to be part of the study. (You can also telephone me. If I don't hear from you in three weeks, I will try to get in touch with you.)

This form does not indicate final consent. We will speak further when we meet, and you can ask any questions. As mentioned before, you are free to withdraw at any time by telling me or Dr. P.A. Field.

Thanks,
Alice.

I have received the letter inviting me to be an informant in the "Becoming a Midwife" study, and I

Would (____)

Would Not (____)

like to speak with the researcher about being a part of the study.

Name:______________________________. Phone:____________________.

APPENDIX C

Information Sheet

INFORMATION SHEET: "BECOMING A MIDWIFE" STUDY
RESEARCHER: Alice J. Rempel

If you consent to be a part of the study, we will arrange to meet at a time and place which is suitable for both of us.

Following the signing of the informed consent, you will be asked to complete a demographic form. This form requests information which may be helpful to more fully understand the results of the study, and for comparison to other studies, should they be in the past, present or future. You will also be assigned (or you may select) a pseudonym and number, which will be the only identification which will appear on the demographics form, interview records, and study reports.

You will then be interviewed by myself on the topic "Becoming a Midwife". It will be your story in which I am interested, particularly those personal decisions, feelings and experiences that precede, accompany and follow your formal or informal educational program. This interview will be audio-taped, and you will be free to give any information which you choose. We will make every effort to keep all identifying information off the audio-tape. This interview will last approximately one hour. Follow-up interviews, in person or by phone, may be arranged if necessary at a time and place that is mutually convenient.

Should you decide at any time that you would like to withdraw any of the information which you have given, you are free to do so. When the analysis is complete, you will be given the opportunity to review the written report, and to withdraw any information which you consider incorrect or detrimental, prior to final release. I may ask you to review the report to confirm my analysis of the data and/or my description of your story.

The audio-tape of the interview may be transcribed by another person. Any remaining identifying information will be removed by the transcriber, who is also bound to confidentiality. All data are kept in a locked compartment, separate from the consent, which is also kept in a locked compartment. This data is kept for a period of seven years, as required by University of Alberta policy. The transcribed interviews and biographical data may be made available for secondary analysis of another researcher, but only after ethical approval by the University of Alberta Ethics Review Committee.

The interview data is compared and contrasted to other interviews, and eventually a theory of the process of "Becoming a Midwife" will emerge. A report will be written outlining this study and its conclusions. A copy of this report remains in the institutional library, and summaries are submitted to various journals for publication. Finally, the findings will be presented at one or more research conferences.

APPENDIX D

Interview Questions

Global question:

Can you tell me your story of how you came to be a midwife? I'd like to know about both your internal, subjective experiences, as well as how you went about getting your education.

Examples of specific questions:

1. When did you first decide to be a midwife? Why?
2. What is your definition of a midwife? How did you come to that definition?
3. What does being a midwife mean to you? How did you arrive at this meaning?
4. What was your first experience of human birth? Was it important to your decision to become a midwife? How?
5. How did you go about getting the knowledge and experience you would need to be a midwife? How long was it after you first started to look for this education that you actually started?
6. Were there any people who were significant in any of these events? Can you tell me how?
7. Were there any people who were like role models or mentors to you? Can you tell me how they were important?
8. What was it like when you first started your learning program? Can you relate how things changed through your program?
9. Have you been responsible for your first complete labor and delivery yet? What was that experience like?
10. Do you feel like you're taking any risks in being a midwife? How? Why? Is that feeling significant to you as a midwife?
11. Was contact with other midwives important to you? Why? How did you maintain contact?
12. Do you feel like you're really a midwife yet? When did you first feel that you were?
13. What makes a midwife different from other health professionals such as physicians or nurses?
14. Can you tell me how you feel about birth? Do you think this is fairly common for all midwives? Do you think this is different from the way other health professionals feel? When did you first feel that way?

APPENDIX E

Biographic Data

Informant pseudonym:____________________Number:___________

Age:_________

Marital status:__________

Education: Type of program Year started Year completed

Nursing:____

Midwifery:____

Other:____

Professional Background:

Type of occupation Year started Year terminated

Nursing:____

Midwifery:____

Other:____

Professional Associations:

____

____

____

____

Personal Child-bearing History:

Date of Birth	Place of birth	Attendants	Complications?

APPENDIX F

Informed Consent

INFORMED CONSENT: "BECOMING A MIDWIFE" STUDY

Graduate Student Researcher: Supervisor:

Graduate Student Researcher	Supervisor
Alice J. Rempel, RN, BN.	P.A. Field, RN, SCM, Ph.D.
446 RH Michener Park	Faculty of Nursing
Edmonton, Alberta T6H 4M5	3rd Floor, Clinical Sciences Building
436-7918	University of Alberta
	492-6248

I have read the explanatory letter for the research project called the "BECOMING A MIDWIFE" STUDY. I have had all my questions and concerns answered.

I understand that I will be expected to be interviewed for approximately one hour, and that follow-up interviews may be requested.

I understand that I may withdraw from the study at any time by simply telling the researcher or her supervisor. Should I choose to do so, I understand that I will be free to withdraw all information which I have previously shared.

I understand that I am free to give only that information in the interview which I wish. I understand that I will be given the opportunity to strike any statement(s) from the interview data if I wish. I understand that I will be given the opportunity to review that portion of the final report that pertains to me, and may ask to have deleted any information that I consider incorrect with regards to myself, that I consider detrimental, or that places me at risk of identification. I understand that a pseudonym will be used in all reports, and that every effort will be made to keep my identity confidential, though complete anonymity may not be possible.

I understand that all interviews will be audio-recorded and transcribed, and that an effort will be made to keep all identifying data off the tape, and any that does appear will not be transcribed. I understand that only recorded material or written material which I freely give will be included in the data, and that informal conversations with the researcher will not be included in the data.

I understand that my full name and address will appear only on the consent form which will be kept in a locked compartment. I understand that only the primary researcher will have access to my identity. The consent form will be kept in a different place than the biographic information, tapes and transcribed data. I understand that I will only be identified by a pseudonym and number on the biographic form, tapes and transcribed data.

I understand that I will receive a copy of the information letter and consent form.

I understand that the transcribed interviews and biographic data may by made available for secondary analysis by another researcher, but only after ethical clearance by the University of Alberta.

Initials:________

INFORMED CONSENT: "BECOMING A MIDWIFE" STUDY (Page 2)

I consent to be a part of this study.

Name:____

Address:______________________________________

Phone: Day:________________Evening:________________

Signature:____________________Date:______________

Researcher:____________________

Pseudonym:____________________Number:______________